PRO MED
Kaleidoscope of Medical Review Services

Send completed form & documents to:
P.O. Box 941870
Maitland, FL 32794
T: 407-599-9122
TF: 866-599-9122
F: 407-599-1994
www.gopromed.com/forms

MEDICARE SET - ASIDE SERVICE REQUEST

WORKERS COMP ☐ ***LONGSHORE*** ☐ ***LIABILITY*** ☐ ***FEDERAL*** ☐
(Please choose appropriate service/s)

Complete MSA ☐
(Allocation report with Submission)

Allocation Report Only ☐

Lien Research ☐

Reopen ☐

Update ☐

**Date of Last report: _____

CASE INFORMATION

Claimant Name (First, Middle Initial, Last)			Date Referred / Date of Birth
Address			Date of Injury
City	State	Zip Code	Social Security Number
Employer		Jurisdictional State	Claim Number

KEY CONTACT & BILLING INFORMATION (please choose referring party option)

Referring Party ○	Adjuster Name	Adjuster Location	Telephone Number	E-mail Address
	Carrier/TPA/Servicing Agent		Mailing Address :	
Referring Party ○	Defense Attorney Name		Telephone Number	E-mail Address
	Defense Attorney Firm		Mailing Address :	
Referring Party ○	Plaintiff Attorney Name		Telephone Number	E-mail Address
	Plaintiff Attorney Firm		Mailing Address :	

Please provide copies of the allocation report to (Explain)
Carrier/TPA/Servicing Agent ☐ Defense Attorney ☐ Plaintiff Attorney ☐ Other ☐

Party Responsible for Invoice
Carrier/TPA/Servicing Agent ☐ Other; explain ☐

FILE INFORMATION

1. Social Security Benefits Status	Claimant Applied ☐	Denied ☐	Appealing ☐	Receiving ☐
2. Is the claimant currently a Medicare Beneficiary?	YES ☐	NO ☐		UNKNOWN ☐
3. Have the releases been sent to plaintiff attorney/ claimant?	YES ☐	NO ☐		UNKNOWN ☐
4. Are there any controverted issues? If so, Please note in box below	YES ☐	NO ☐		UNKNOWN ☐
5. Has this file been settled? (if yes how much)	YES ☐	$ _____		NO ☐
6. Has a rated age been obtained? If yes broker name below	YES ☐	NO ☐		UNKNOWN ☐
7. Who will be handling CMS submission?	PRO MED ☐			OTHER ☐

REPORT TIME FRAME

Routine Turnaround = 14 days ☐ Normal Status ☐ RUSH Status

If RUSH is requested, please provide dated report is needed:

Preferred Structure Company **Contact Number**

PLEASE PROVIDE ANY SPECIAL HANDLING INSTRUCTIONS BELOW:

Documents Needed:

PHASE I

1. First Report of Injury
2. 2 years of Medical records
3. 2 year of RX
4. 2 years of Medical bills
5. 2 years of Payment History
6. Judges Orders / Decisions on Medical treatment

PHASE II

6. Social Security document?
7. Settlement Documents or signed agreement
8. Signed releases
9. Copy of Medicare Card

(For Internal Use)

Submit PRO MED file # :

Revised 01/20/09