P.O. Box 941870
Maitland, FL
32794
T: (407) 599.9122
or (877) 599.9122

Medicare Secondary Payer Mandatory Reporting Form

WC ☐ **Liability** ☐ **Health** ☐

Medicare Number or SS#:		Date of Incident:	
Claim #:			

Claimant Name:		Claimant Address:	
Date of Birth:			

Employer or Insured:		Employer or Insured Address:	
Adjuster:		Carrier Address:	
Carrier:			

Claimant Attorney:		Attorney Address:	

Original Injury(s):			

Complete MSA ☐ **YES** ☐ **NO**

Complete Conditional Payment ☐ **YES** ☐ **NO**

FAX TO: (407) 599.1994 **EMAIL TO:** Referral@gopromed.com

Submit Form

August 2008