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|--|-----------------------------------|
| <b>MEDICARE SERVICES ASSIGNMENT FORM</b> |                                   |
| (PIP / No-Fault)                         |                                   |
| REQUESTED SERVICE (CHECK ALL THAT APPLY) |                                   |
| Medicare Set-Aside (MSA) Allocation      | Platinum MSA Service (7-day Rush) |
| Conditional Payment Claim Inquiry        | Medical Cost Projection (MCP)     |

| CASE INFORMATION                     |                     |               |
|--------------------------------------|---------------------|---------------|
| Claimant Name:                       |                     |               |
| Date of Birth:                       | SSN:                | Gender (M/F): |
| Current Address:                     |                     |               |
| City:                                | State:              | ZIP Code:     |
| Telephone:                           | Injury Description: |               |
| Date of Injury:                      |                     |               |
| Claim No.:                           | Accident Location:  |               |
| INSURED (IF DIFFERENT THAN CLAIMANT) |                     |               |
| Policy Holder Name:                  |                     |               |
| Address:                             |                     |               |
| City:                                | State:              | ZIP Code:     |
| Phone:                               | Policy No.:         |               |
| INSURER                              |                     |               |
| Adjuster Name:                       |                     |               |
| Insurer Name:                        |                     |               |
| Insurer Address:                     |                     |               |
| City:                                | State:              | ZIP Code:     |
| Phone:                               | E-mail:             | Fax:          |
| DEFENSE ATTORNEY                     |                     |               |
| Attorney Name:                       |                     |               |
| Firm Name:                           |                     |               |
| Mailing Address:                     |                     |               |
| City:                                | State:              | ZIP Code:     |
| Phone:                               | E-mail:             | Fax:          |
| PLAINTIFF ATTORNEY                   |                     |               |
| Attorney Name:                       |                     |               |
| Firm Name:                           |                     |               |
| Mailing Address:                     |                     |               |
| City:                                | State:              | ZIP Code:     |
| Phone:                               | E-mail:             | Fax:          |

CASE INFORMATION CONTINUED

Has Claimant applied for or received Social Security Disability Income?

Is the Claimant currently a Medicare beneficiary?

Has Maximum Medical Improvement been established?

What is the PIP coverage limit for this claim?

Has a proposed settlement been reached?

If yes, what is the proposed settlement value?

Does this amount include an allocation (MSA) for future medical treatment otherwise covered by Medicare?

What diagnoses and/or body parts are accepted on this claim?

What diagnoses and/or body parts are denied or disputed on this claim?

REQUIRED DOCUMENTATION FOR CONDITIONAL PAYMENT INQUIRY

- ✓ Letter of Authority from Insurer
- ✓ Documentation of injury specific to this case

REQUIRED DOCUMENTATION FOR MSA / MCP

- ✓ Most recent 2 years of medical records
- ✓ Most recent 2 years of medical payment (expense) ledgers
- ✓ Most recent 2 years of prescription history / records
- ✓ Consent / Release forms may be also be required for MSA assignments

ADDITIONAL INSTRUCTIONS / COMMENTS

PLEASE RETURN COMPLETED FORM AND DOCUMENTATION TO:

**James E. Logan & Associates**

28175 Haggerty Road  
Novi, MI 48377  
(248) 865-3905 FAX

Email to: [info@logansettlements.com](mailto:info@logansettlements.com)

If you have any questions, please contact us at (248) 865-3900.