PRECISION RESOLUTION

New Case Intake Form

Date of Request _____/_____/_____

So that Precision may begin processing your file immediately, please submit this completed form, along with any/all additional authorization forms to ***intake@precisionlienresolution.com***

Attorney Information

Name _____

Phone _____ Fax _____

Firm _____

Address _____

City _____State _____ Zip _____

Attorney Email _____

Paralegal/Associate Contact _____

Paralegal/Associate Email _____

Claimant Information

Name _____

Gender ☐ Female ☐ Male

SSN _____ DOB _____/_____/_____

Address _____

City _____State _____ Zip _____

Phone _____

Has claimant lived in another state since date of injury? Yes* ☐ No ☐

*If yes, what state(s)? _____

Settlement Information

Has this case settled? ☐ Yes ☐ No Settlement Amount $_____

Settlement/Anticipated Settlement Date _____/_____/_____

Comments

Nature of Injury

DOI_____/_____/_____ DOD (if applicable) _____/_____/_____

Specific Nature of Accepted Injuries

Still Treating ☐ Yes ☐ No Last Treatment Date _____/_____/_____

Known Pre-Existing Conditions

Nature of Claim (check all that apply)

☐ Motor Vehicle Accident

NO-FAULT

No Fault Policy? ☐ Yes ☐ No

No Fault Carrier Full & Proper Name

APIP

Might APIP be Obligated to Pay Medicals? ☐ Yes ☐ No

APIP Carrier Full & Proper Name

Policy Limit $_____

☐ Medical Malpractice ☐ Exposure _____

☐ Nursing Home Negligence ☐ Product Liability _____

☐ Slip & Fall ☐ Other_____

LIABILITY

Liability Carrier Full & Proper Name

Policy Limit $_____

WORKERS' COMP

WC Carrier Full & Proper Name

Policy Limit $_____

OTHER BENEFITS RECEIVED

☐ Social Security Disability Insurance Start _____/_____/____ End _____/_____/____

☐ Supplemental Security Income Start _____/_____/____ End _____/_____/____

☐ Other _____ Start _____/_____/____ End _____/_____/____

Services Requested Check all that Apply		Claimant Receiving (Past or Present)	Case Reported to Agency	Relevant Claim Information Please submit a copy of any/all correspondences with agency and claimant's insurance cards along with this and all other authorization forms to intake@precisionlienresolution.com
☐	Medicare Conditional Payment (Parts A/B)	☐	☐	HIC # _____ Entitlement Date _____/_____/_____
☐	Medicare Advantage (Parts C/D)	☐	☐	Insurance Company Name _____ Group/ID # _____
☐	Medicaid	☐	☐	Medicaid # _____ State(s) _____
☐	Self-Funded ERISA or Other Private Healthcare	☐	Plan Docs Requested? ◯ Yes ◯ No	Insurance Company Name _____ Group/ID # _____ If Employer-based Health Plan, specify employer name _____ Please provide Plan Document or Summary Plan Description if available.
☐	TRICARE	☐	☐	Treatment Facilities _____ Sponsor SSN_____
☐	Veteran's Administration	☐	☐	Treatment Facilities _____ Sponsor SSN_____
☐	Medicare Set-Aside Allocation	Liability ☐	Workers' Compensation ☐	Please forward the following documents for MSA Services: ■ Past 2 Years of Records/Reports from Claimant's Treating Physicians ■ Past 3 Years of Payment History or Medical Benefits ■ Past 3 Years of IME Reports ■ Bill of Particulars Date of Medicare Eligibility_____/_____/_____ HIC#_____
☐	Medicare Set-Aside Opinion Letter	Liability ☐	Workers' Compensation ☐	