PRECISION RESOLUTION, LLC

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)? _____

Personal Representative/Administrator of Affairs

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	☐	☐	Insurance Company Name _____ Group/ID # _____ If Employer-based Health Plan, specify employer name _____ *Please provide Plan Document or Summary Plan Description if available. Enter additional provider(s) info in Comments section below, as needed.
☐	Other Private Health Insurance	☐	☐	
☐	TRICARE	☐	☐	Treatment Facilities _____ Sponsor SSN_____
☐	Veteran's Administration	☐	☐	Treatment Facilities _____ Sponsor SSN_____

Additional Comments

Authorization for Use and Disclosure of Protected Health Information
Pursuant to the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA) (45 C.F.R. §164.508)

In Reference To:

Patient Name	Date of Birth	Social Security Number

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. Information disclosed under this authorization might be redisclosed by the recipient, and this redisclosure may no longer be protected by federal or state law.

PURPOSE OF AUTHORIZATION:
To provide a full disclosure of any information to Precision Resolution, LLC, its agents, employees, affiliates, subsidiaries, or representatives is to enable an assessment and evaluation to prepare a Future Medical Cost Projection, and/or Medicare Set-Aside Arrangement or commence a lien resolution action. Note that the claimant may revoke this Authorization at any time by written notice to Precision Resolution, LLC, its agents, employees, affiliates, subsidiaries, or representatives, but that any revocation shall have no effect on actions which have been taken prior to receiving. Any personal health information that the Claimant authorized to disclose may be subject to redisclosure and no longer protected by law.

ENTITIES AUTHORIZED TO RELEASE THE INFORMATION:
Healthcare Provider, Insurer, Collection Agent:

ENTITIES AUTHORIZED TO RECEIVE, USE, AND DISCLOSE THE INFORMATION:
Precision Resolution, LLC, its agents, employees, affiliates, subsidiaries, or representatives.

Mailing Address:
Precision Resolution, LLC
4134 Seneca Street
Buffalo, NY 14224

Date or Event on which this authorization will expire:

Until the conclusion of my personal injury action.

LIST OF INFORMATION TO BE RELEASED:
Entire Medical Record, including patient histories, office notes (except psychotherapy notes), lab/test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

Name of Entity to Release Information:
Address of Entity to Release Information

I have read and understand the contents of this Authorization and have had the opportunity to discuss same with counsel of my choice. The contents of this Authorization confirm, and are consistent with, my authority, instructions, or directions to Precision Resolution, LLC and their Employees and Representatives and I understand that by executing this Authorization, I am authorizing Precision Resolution, LLC and their Employees and Representatives to use and disclose, as permitted and outlined herein, certain nonpublic information. All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the forms.

Claimant/Injured Party Signature	Claimant/Injured Party Name	Date

OR

Personal Representative Signature	Print name, and Title (based on authority to act) (i.e.,guardianship /conservatorship letters of authority, powers of attorney, etc. attached)	Date

Medicare Secondary Payer Compliance and Medicare Lien Resolution Services

From the first point of contact and reporting the case to CMS, tracking the file through Medicare's system, to analyzing the Conditional Payment letter and Payment Summary Form and challenging the lien amount, Precision will secure a timely and equitable resolution of the Medicare component of the plaintiff's case.

MEDICARE SECONDARY PAYER COMPLIANCE AND LIEN RESOLUTION FEE SCHEDULE

$500 ONE TIME FEE PER CASE	PLUS, IN THE EVENT OF A REDUCTION OF THE LIEN BY WAY OF PRECISION'S SUCCESSFUL CHALLENGE	10% OF THE REDUCTION WITH A PER CASE CAP ON FEES OF $5,500.00

Medicaid, ERISA, Medicare Advantage Plan and Other Healthcare Lien Resolution

Precision employs case specific action plans when handling the reduction of Medicaid, ERISA, Medicare Advantage Plan and other healthcare lien matters. It is for this reason that we request having a **10 minute Lien Screen conference call to discuss the case prior to retention**.

MEDICAID, ERISA, MEDICARE ADVANTAGE PLAN AND OTHER HEALTH CARE LIEN RESOLUTION SERVICES

SERVICE & CASE PROGRESSION	FEES
STEP 1: Precision will procure lien amount, medical billing codes and payment summaries and advise counsel as to whether or not a challenge of the lien amount is warranted.	$250 PER LIEN CLAIM
STEP 2: Should counsel wish for Precision to engage in resolving the lien amount, Precision will draft & file the necessary challenge and negotiate a reduction of the lien.	*PLUS* $750 PER LIEN CLAIM
STEP 3: Precision secures a reduction of the lien amount by way of successful challenge, prior to the engagement of litigation of the lien amount.	*PLUS* 15% APPORTIONMENT OF THE REDUCTION OF THE LIEN AMOUNT
STEP 4, WHERE NECESSARY: IN MATTERS WHERE LITIGATION OF THE LIEN IS REQUIRED: When Precision secures a reduction of lien amount by way of litigation of the lien amount.	**OR, IF LITIGATED** 25% APPORTIONMENT OF THE REDUCTION OF THE LIEN AMOUNT

Medicare Set-Aside Allocations, Submissions, and Opinion Letters

MEDICARE SET-ASIDE SERVICES

MEDICARE SET-ASIDE ALLOCATION	MEDICARE SET-ASIDE ALLOCATION SUBMISSION	MEDICARE SET-ASIDE LETTER OF OPINION
$2200 PER ALLOCATION Our allocators and attorneys jointly prepare your client's MSA so as to minimize the future obligations while ensuring that appropriate rules and guidelines are followed.	VARIABLE PRICING Precision will submit the completed allocation to CMS so that your firm may document your compliance with appropriate CMS protocol.	STARTING AT $500 Precision's attorneys will review the facts of the case and render an opinion as to whether or not an MSA is appropriate for your client.