



MSA Services

10809 Executive Center Dr., STE.105, Little Rock, AR 72211
Tel. 501.227.5553 or 800.822.2680 / Fax. 501.227.8362

REFERRAL FORM

CASE INFORMATION

Claimant Name (First, Middle Initial, Last)			Date of Birth
Address			Date of Injury
City	State	ZIP	Social Security Number
Defendant/Insured	Attorney		Claim Number

REFERRING PARTY

Adjustor or Attorney Name	
Company/Firm	
Address	
City/State/Zip	
Phone	Email

INVOICE FOR MSA SERVICES TO:

<input type="checkbox"/> Same as referring party noted above. (If different from referring party please fill in information below:)	
Name	
Company	
Address	
City/State/Zip	
Phone	Email

ICD-9 CODES (VERY IMPORTANT! Enter all codes used when this claim was originally reported to Medicare.)

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SOCIAL SECURITY/MEDICARE STATUS

	Yes	No	Not Known
Has claimant applied for Social Security Disability Benefits (SSDI)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has claimant been denied SSDI?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is claimant appealing SSDI denial?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has claimant been awarded SSDI, but not receiving benefits?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is claimant now receiving SSDI benefits?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is claimant now covered by Medicare?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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Has claim been settled? Yes No

If settled, amount: \$

Where do you want Systemedic to send copies of the completed MSA Report?

Name _____

Name _____

Title _____

Title _____

Company _____

Company _____

Address _____

Address _____

City/State/Zip _____

City/State/Zip _____

The following documents are REQUIRED by CMS in order to complete your MSA:

- First Report of Injury
- Previous three years of medical records & bills (if claim is less than 3 yrs. old, send all to date)
- Previous three years pharmacy records & bills (if claim is less than 3 yrs. old, send all to date)
- Previous three years payment history, with current run date, for medical, pharmacy & indemnity (if claim is less than 3 yrs. old, send all to date)

Send the completed Referral Form to Systemedic using one of the two methods below:

- Fax Referral Form to the attention of MSA Services at 501-227-8362, or
- Email to msa@systemedic.com

Send a paper copy of the Referral Form, with the medical records and all other required documents listed in the box above, using one of the methods below:

- Current customers with regular courier pick up may use the service to forward the package to Systemedic.
- Local customers who do not have existing courier service to Systemedic may call 227-5553 for courier pick-up.
- Non-local customers use US First Class, FedEx, or UPS to:

Systemedic Corporation
MSA Services
10809 Executive Center Drive, STE. 105
Little Rock, AR 72211
501-227-5553

NOTES, SPECIAL HANDLING (Hearing dates, controverted issues, specific requests, etc.)
