

Medicare Set-Aside Request

Date: _____

Claimant Name: _____ Address: _____

Claim Number: _____ Social Security Number: _____

Date of Birth: _____ Date of Injury: _____ State of Venue: _____

Plaintiff Attorney: _____ Address: _____

Phone: _____ Email: _____

Defense Attorney: _____ Address: _____

Phone: _____ Fax: _____ Email: _____

Claimant's Employer: _____ Address: _____

***Please List All Compensable Components:**

Claim Handler/Adjuster: _____

Contact Phone: _____ Email address: _____

Services Requested: MSA ___ QMSA ___ Revision ___ Life Care Plan ___ Other ___

This form may be emailed to Support@MSASpecialists.com or faxed to (813) 891-9120. If you have questions, please call (866) 897-4MSA. Our website is www.MSASpecialists.com