



FARA HEALTHCARE SERVICES
REFERRAL FORM – Medical Cost Projection

Claimant:		Carrier:	
Address:		Address:	
Phone:		Phone/Fax:	
SSN:		Email:	
HICN:		Contact Person:	
Medicare Part A Entitlement Date:		Medicare Part B Entitlement Date:	
Medicare Part D Entitlement Date:		Claims Adjuster:	
Medicaid:		SSDI:	
DOB:		OWCP:	
DOI:		State of Jurisdiction:	
Rated Age:		Proposed Settlement Date:	
Sex:		Employer:	
Accepted Compensable Injury:		Address:	
ICD Code:		Defense Attorney:	
Claimant Attorney:		Address:	
Address:		Phone/Fax:	
Phone/Fax:		Email:	
Email:		Professional or Self-Administration of MSA:	
SPECIAL INSTRUCTIONS:			