



FARA HEALTHCARE SERVICES REFERRAL FORM - MSA

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