



GISCLAIR MEDICAL SERVICES, LLC

10101 Siegen Lane,
Bldg. 2, Suite C
Baton Rouge, LA 70810
Phone: 225-768-7282
Facsimile: 225-768-7284

REFERRAL INFORMATION

Date of referral: _____
Type of claim: WC _____ Liability _____ Claim # _____
State of jurisdiction _____

Services requested (check all that apply):
Social Security and Medicare Status Determination
Medicare Set-Aside Cost Projection without submission to CMS (includes pharmacy)____
Medicare Set-Aside Allocation Cost Projection with submission to CMS____
Additional Service (expedited submission)
Investigate "Conditional Payments"? Yes _____ No _____
Prescription Drug Utilization Review? Yes _____ No _____

Claimant name _____ Phone # _____
Claimant address _____
Diagnosis related to this claim _____
DOI _____ SS# _____ DOB _____
Employer/Insured _____
Address _____
Phone/Ext. _____ E-mail address _____

Referral source _____
Address _____ Phone # _____
E-Mail _____

Payer/Insurance Company information if different from above _____
Payer name _____
Payer address _____
Phone/Ext. _____ E-mail address _____

Defense counsel name _____ Phone # _____
Defense counsel address _____
Defense counsel e-mail _____

Plaintiff counsel name _____ Phone # _____
Plaintiff counsel address _____
Plaintiff counsel e-mail _____

- Has a settlement agreement been reached? Yes _____ No _____
- If yes, list settlement amount: Total _____ (Breakdown below)
Medical _____ Indemnity _____ Attorney Fees _____
- Is a structured settlement broker involved in this settlement?
Yes _____ No _____

- If yes, list name of company _____ Phone _____
- E-mail address _____ Fax _____
- Is the account professionally administered? Yes _____ No _____
- If yes, list professional administrator name _____
- Phone _____ Fax _____
- Address _____
- Has claimant applied for Social Security benefits? Yes _____ No _____
- Has claimant been denied benefits and appealed? Yes _____ No _____
- Is claimant receiving Social Security benefits? Yes _____ No _____
- Are there any known Medicare conditional payment claims? Yes _____ No _____
- Is claimant receiving Medicaid benefits? Yes _____ No _____
- Is this or any portion of this claim disputed or controverted? Yes _____ No _____
- Was a Life Care Plan or Medical Cost Projection done? Yes _____ No _____
- Would you like for GMS to investigate "Conditional Payments? Yes _____ No _____
- List any known condition that is not related to the WC injury: _____

•Additional Comments:

Please forward the following with your completed referral form:

- Original signed consent forms authorizing communication with Medicare/Social Security (3 forms)
- Submitter letter or other summary documentation
- First Report of Injury
- Medical records (last 2 years unless treatment was limited, then last 5 years). All hospital discharge summaries, admission histories and physical reports
- Indemnity payment history and medical payment history
- Life Care Plans, if obtained
- Settlement agreement/proposed or court order
- Set-Aside Administrator or copy of agreement
- Supplemental or additional information
- Pharmacy pay history

GMS responsibility to obtain:

- Future treatment plan
- Future medication
- Rated age on life company letterhead, if obtained

Please forward to:

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