



**LSS OFFICE USE ONLY**

INTERNAL CASE #: \_\_\_\_\_

FEE SCHEDULE: \_\_\_\_\_

ADV PD: \_\_\_\_/\_\_\_\_/\_\_\_\_ AMT: \$ \_\_\_\_\_

CLIENT CONF: Y/N ANALYST: \_\_\_\_\_

COMPLETED: \_\_\_\_/\_\_\_\_/\_\_\_\_

BALANCE PD: \_\_\_\_/\_\_\_\_/\_\_\_\_ AMT: \$ \_\_\_\_\_

## LIEN RESOLUTION INTAKE FORM

*PLEASE FILL OUT AS COMPLETELY AS POSSIBLE*

**SERVICES REQUESTED**

(CHECK ALL THAT APPLY):

VERIFICATION ONLY

LIEN RESOLUTION

PLAN EVALUATION

MEDICARE SET ASIDE

OTHER \_\_\_\_\_

**INSURANCE TYPE**

(CHECK ALL THAT APPLY):

MEDICARE

MEDICAID – STATE PLAN

MILITARY (VA/TRICARE)

ERISA/ PRIVATE HEALTH

OTHER \_\_\_\_\_

**CASE TYPE (CHECK ALL THAT APPLY):**

PERSONAL INJURY

PRODUCT LIABILITY

MOTOR VEHICLE ACCIDENT

WORKERS COMPENSATION

WRONGFUL DEATH

OTHER \_\_\_\_\_

PLEASE INCLUDE ANY CORRESPONDENCE RECEIVED FROM INSURERS AND RECOVERY CONTRACTORS, ALONG WITH A COPY OF CLAIMANT'S INSURANCE CARDS (IF AVAILABLE). A SIGNED AUTHORIZATION **MUST** BE RECEIVED FROM THE CLIENT BEFORE A CASE CAN BE INITIATED. SUBMIT ADVANCE PAYMENT ALONG WITH COMPLETED INTAKE FORM AND AUTHORIZATION FORM TO THE ADDRESS BELOW.

**CLAIMANT INFORMATION**

NAME: \_\_\_\_\_

SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_ GENDER: MALE / FEMALE

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: (\_\_\_\_) \_\_\_\_-\_\_\_\_

IF DEPENDENT, PLEASE IDENTIFY CONTACT:

NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_-\_\_\_\_

**INSURANCE INFORMATION**

MEDICARE #: \_\_\_\_\_

MEDICAID ID: \_\_\_\_\_

SPONSOR #: \_\_\_\_\_

INSURER: \_\_\_\_\_

POLICY #: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

**CASE INFORMATION**

DATE OF LOSS: \_\_\_\_/\_\_\_\_/\_\_\_\_

INJURY: \_\_\_\_\_

DESCRIPTION OF INCIDENT: \_\_\_\_\_

\_\_\_\_\_

LIABILITY INSURER/DEFENSE ATTORNEY/DEFENDANT: \_\_\_\_\_

\_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_-\_\_\_\_

**CLIENT INFORMATION**

ATTORNEY NAME: \_\_\_\_\_

FIRM: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: (\_\_\_\_) \_\_\_\_-\_\_\_\_ FAX: (\_\_\_\_) \_\_\_\_-\_\_\_\_