Landmark Lien Resolution, Inc.

Lien Resolution Services

Case Referral Checklist

The Case Referral Checklist is provided for your convenience so it is not necessary to complete and return the checklist when sending a case referral. Please contact us if you have any questions regarding the case referral form, agent authorizations, or any of the contents contained within this document.

☐ **Case Referral Form (Pg. *2*-4):** *Complete with all accident and insurance information.*
Note: The Case Referral Form is an editable pdf so it is not necessary to print and complete by hand.

☐ **Law Firm Agency Auth (Pg. *6* & *7*):** *Complete, print on your letterhead, and sign.*

- ☐ General Agency Authorization **(Pg. *6*):** Necessary for Medicare Advantage, ERISA, Fully-Insured, FEHBA, VA, TriCare, and provider liens.
- ☐ Medicare Agent Authorization **(Pg. *7*):** Necessary for Traditional Medicare Liens only.
Note: In addtion to the Medicare Agent Authorization CMS requires we provide your Retainer Agreement or a completed Proof of Representation **(Pg. *8*)**.

☐ **Medical Authorization:** *Provide a copy of your medical authorization form signed by the client.*

☐ **Landmark Service Referral Letter:** *Review and contact us if you have any questions.*

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Landmark Lien Resolution Inc.

Case Referral Form

SERVICE(S) REQUESTED

☐ LIEN RESOLUTION ☐ LIEN VERIFICATION ☐ PLAN EVALUATION ☐ OTHER

CLAIMANT INFORMATION:

NAME: ______ ADDRESS: ______

CITY: ______ STATE/ZIP: ______

SSN: ______ DOB: ______ PHONE: ______ GENDER: ______

For Dependent(s), please provide guardian or personal representative information:

NAME: ______ TITLE: ______

RELATIONSHIP TO DEPENDENT: ______ PHONE: ______ EMAIL: ______

Claimant Employment Information

CURRENTLY EMPLOYED: ______ EMPLOYER NAME (Current): ______

EMPLOYED AT TIME OF INJURY: ______ EMPLOYER NAME (at time of injury): ______

CLAIMANT ATTORNEY:

NAME: ______ FIRM: ______

ADDR: ______ CITY,ST,ZIP: ______

EMAIL: ______ PHONE: ______ FAX: ______

CASE INFORMATION:

HAS UNDERLYING PERSONAL INJURY CASE SETTLED? ______ If yes, settlement amount: $ ______

ATTORNEY CONTINGENCEY FEE: % ______ CASE/LAWSUIT EXPENSES: $ ______

TOTAL CLAIMANT “OUT-OF-POCKET” EXPENSES: $ ______ LOST WAGES: $ ______

RECOVERY SOURCE AND POLICY LIMITS:

THIRD PARTY BI COVERAGE: $

FIRST PARTY (UM/UIM): $

HOMEOWNER'S POLICY: $

GENERAL LIAB or UMBRELLA: $

3rd PARTY PERSONAL ASSETS: $

OTHER: $

CARRIER NAME:

CLAIM NUMBER:

INJURY INFORMATION:

CASE TYPE:

DATE OF INJURY:

DESCRIPTION OF INCIDENT (*Please include location*):

DESCRIPTION OF INJURIES:

PRE-EXISTING CONIDTIONS:

LAST TREATMENT DATE:

FUTURE TREATMENT REQUIRED?

HAS CLIENT HAD SURGERY AS RESULT OF INJURY?

If yes, surgery type:

INSURANCE/LIEN INFORMATION:

HEALTH INSURANCE CO:

POLICY #:

PLAN TYPE:

LIEN AMOUNT:

RECOVERY AGENT (Include contact info if available):

If Medicaid, STATE:

If Military (VA OR TRICARE), BRANCH AND RANK:

Additional Liens

INSURANCE/LIEN INFORMATION:

HEALTH INSURANCE CO:
POLICY #:
PLAN TYPE:
LIEN AMOUNT:
RECOVERY AGENT (Include contact info if available):

If Medicaid, STATE:
If Military (VA OR TRICARE), BRANCH AND RANK:

INSURANCE/LIEN INFORMATION:

HEALTH INSURANCE CO:
POLICY #:
PLAN TYPE:
LIEN AMOUNT:
RECOVERY AGENT (Include contact info if available):

If Medicaid, STATE:
If Military (VA OR TRICARE), BRANCH AND RANK:

INSURANCE/LIEN INFORMATION:

HEALTH INSURANCE CO:
POLICY #:
PLAN TYPE:
LIEN AMOUNT: $
RECOVERY AGENT (Include contact info if available):

If Medicaid, STATE:
If Military (VA OR TRICARE), BRANCH AND RANK:

INSURANCE/LIEN INFORMATION:

HEALTH INSURANCE CO:
POLICY #:
PLAN TYPE:
LIEN AMOUNT: $
RECOVERY AGENT (Include contact info if available):

If Medicaid, STATE:
If Military (VA OR TRICARE), BRANCH AND RANK:

Agent Authorization Instructions

The General Agent Authorization is used for <u>all lien types except</u> Traditional Medicare. This includes Medicare Advantage, ERISA, Fully-Insured, FEHBA, VA, Tricare, and provider liens. If you are referring a Medicare lien as well as any other lien type, both the Medicare Agent Authorization and the General Agent Authorization needs to be completed and returned.

<u>General Agent Authorization Instructions (Pg.6)</u>

1. Insert today's date in top left section of authorization.
2. Insert Client Name (Note: **Do not complete** HealthPlan/Provider or ID# fields).
3. Insert Attorney's name in signature line of authorization.
4. Print on Firm/Attorney letterhead and sign.
5. Return completed Agent Authorization with a copy of your medical authorization form signed by the client.

<u>Medicare Agent Authorization Instructions (Pg. 7-8)</u>

1. Insert today's date in top left section of authorization.
2. Insert Client Name (Plan Member), Medicare Policy ID (HICN), and the date of injury.
3. Insert Attorney's name in signature line of authorization.
4. Print on Firm/Attorney letterhead and sign.
5. Return completed Medicare Agent Authorization **AND**
   a) Retainer Agreement **OR** b) Completed Proof of Representation **(Pg. 8)**.

Re: Agency Authorization for Landmark Lien Resolution Inc.

Plan Member/Patient:
Health Plan/Provider:
ID#:

To Whom It May Concern:

As the attorney representing the above named plan member, I hereby appoint, as its agent, Landmark Lien Resolution Inc., with authority to contact and to correspond with the health plan with respect to compromising and resolving any and all payments made on behalf of the above referenced plan member.

This agency includes authorization for Landmark Lien Resolution to send and receive documents and to take any activity that I would otherwise be entitled to do as attorney for the above named beneficiary, including verification of payments, reduction requests, waiver requests and/or appeals on behalf of the plan member.

Please include Landmark Lien Resolution on any future correspondence. Also, please let us know if you have any questions or require additional information about the contents of this letter.

AGENT: Landmark Lien Resolution
4071 Tates Creek Centre Dr., Ste 110
Lexington, KY 40517

Sincerely,

____

Insert Attorney Name, Print on Letter Head, and Sign

Insert today's date

Benefits Coordination & Recovery Center (BCRC)
NGHP
P.O. Box 138832
Oklahoma City, OK 73113

Plan Member:	Insert Client Name
HICN:	Insert Medicare Policy ID
DOI:	Insert Date of Injury

To Whom It May Concern:

As the attorney representing the above named Medicare beneficiary, I hereby appoint, as its agent, Landmark Lien Resolution, with authority to contact and to correspond with the Centers for Medicare and Medicaid Services (CMS) and the Benefits Coordination & Recovery Center (BCRC) with respect to compromising and resolving any and all conditional payments made on behalf of the above referenced Medicare beneficiary.

This agency includes authorization for Landmark Lien Resolution to send and receive documents and to take any activity that I would otherwise be entitled to do as attorney for the above named beneficiary, including verification of conditional payments, reduction requests, waiver requests or appeals on behalf of the beneficiary.

Please include Landmark Lien Resolution on any future correspondence. Also, please let us know if you have any questions or require additional information about the contents of this letter.

AGENT:	Landmark Lien Resolution
ADDRESS:	4071 Tates Creek Centre Dr., Ste. 110
	Lexington, KY 40517

Sincerely,

____

Insert Attorney Name, Print on Letter Head, and Sign

Insert today's date

Benefits Coordination & Recovery Center (BCRC)
NGHP
P.O. Box 138832
Oklahoma City, OK 73113

PROOF OF REPRESENTATION

The undersigned Medicare beneficiary hereby authorize CMS, its agents and/or contractors to release, upon request, any and all conditional payment information and all personal health information related to my injury/illness and/or settlement for the specified date of injury/illness to the undersigned authorized representative. The undersigned authorized representative declares and agrees that they represent the undersigned Medicare beneficiary and may take all actions necessary to represent said beneficiary for purposes of discussing, verifying, compromising and fully resolving any and all Medicare conditional payments relating to beneficiary's personal injury claim(s).

Type of Beneficiary Representative: Authorized Representative:

( ) Individual other than an Attorney	Name: Insert Attorney Name
(X) Attorney*	Firm Name: Insert Firm Name
( ) Guardian*	Address: Insert Attorney Address
( ) Conservator*	Telephone: Insert Attorney Phone #
( ) Power of Attorney*	

If the beneficiary is incapacitated, his/her guardian, conservator, power of attorney, etc. will need to submit additional required supporting documentation in addition to this proof of representation.

Medicare Beneficiary's Name, HICN and DOI:

Beneficiary's Name (please print exactly as shown on your Medicare card): Insert Client Name

Beneficiary's Health Insurance Claim Number (number on your Medicare card): Insert Medicare Policy ID

Date of Illness/Injury: Insert Date of Injury

Signature of Beneficiary and Representative:

Beneficiary Signature:________________________________ Date Signed: ______________________

Representative's Signature:____________________________ Date Signed:______________________

Landmark Lien Resolution Signature:____________________ Date Signed: ______________________