MSARiskPro®
a division of BlackburnGroup INC.

Accelerated Settlement
Workers' Compensation and Liability Claim Referral Form

Claimant's Information:

Name (Last Name, First & Middle Initial)	Street Address, City State & Zip Code
Social Security Number:	**Date of Birth:**
Date of Injury:	**State of Jurisdiction:**
Employer Name:	**Employer Address:**
Date of Hire:	**Claim #:**

Referring Contact Information:

Attorney Name	Address	Phone #:	E-Mail:
Ins. Carrier/TPA/Self Ins./Other	**Address**	**Phone #:**	**E-Mail:**

Additional Attorney Information (If Applicable):

Defense Attorney	Address	Phone #:	E-Mail:
Claimant's Attorney	**Address**	**Phone #:**	**E-Mail:**

What is this type of Case? Workers Compensation, Liability, No-Fault? _____

Is the Claimant on Medicare? Yes _____ or No_____ or N/A / Unknown _____

Is the Claimant on Medicaid? Yes _____ or No_____ or N/A / Unknown _____

Date of Medicare Eligibility: _____ or N/A / Unknown _____

Is the Claimant's Medicare Card available? Yes ____ or No____ Is the card attached with this referral? Yes____ or No ____

Is the Claimant on SSDI? Yes _____ or No _____ or N/A / Unknown _____

Date of SSDI Eligibility: _____ or N/A / Unknown _____

Has this claim been settled? Yes ____ or No ____ Total settlement amount: $ _____ Has it been approved? Yes ____ or No ____

Please list all accepted injuries and date of each injury:

_____

Please list all disputed injuries and reason for dispute:

_____

Please complete form and email with signed releases to:

support@blackburngroup.com

Blackburn Group, Inc., P.O. Box 142, Penfield, NY 14526