Hummel Consultation Services - New Referral Submission Form

For questions please call (603) 758-1410

Client

If the primary contact is not the contracting party responsible for paying our invoices, please attach a separate explanatory statement.

Name of primary contact

Company or firm

Address

Phone	Fax	Email

Claimant

Name

Address

Date of birth	SSN	HICN, MBI, or Medicare Number

Claimant Attorney

If multiple attorneys are involved, list the lead attorney here and attach a statement listing all other attorneys and their contact information.

Is the claimant legally represented? ☐ Yes ☐ No

Name of lead claimant attorney

Firm

Address

Phone	Fax	Email

Does any person have Power of Attorney over the claimant? ☐ Yes ☐ No
If yes, attach supporting documents

SSD and Medicare

☐ Yes ☐ No Is the claimant currently receiving Social Security Disability benefits?
If yes, what is the date of eligibility? _____

☐ Yes ☐ No Is the claimant currently applying to receive Social Security Disability benefits?
If yes, when did the claimant apply? _____

☐ Yes ☐ No Is the claimant currently appealing a denial of Social Security Disability benefits?
If yes, when was the appeal filed? _____

☐ Yes ☐ No Is the claimant currently receiving Medicare benefits?
If yes, what is the date of eligibility? _____

☐ Yes ☐ No Has the claimant ever participated in either or both of a Medicare Part C or a Medicare Part D plan?
If yes, names of plans: _____

Claim

File and/or claim numbers

Date(s) of accident, injury or illness. Also indicate ongoing or occupational dates, if any

Type of claim, check all that apply

- ☐ Workers' Compensation
- ☐ Longshoremen and Harbor Workers' Compensation Act
- ☐ Federal Employees Compensation Act
- ☐ Third Party Liability or No-Fault; specific nature of the claim: _____
- ☐ Jones Act
- ☐ New Jersey Section 20 (please contact us for additional information needed for complete referral submission of a NJ Section 20)

State of jurisdiction, or controlling state law, if any

Accepted ICD codes for the accident, injury or illness

Defendant / Respondent

If multiple defendants are involved, list the lead defendant here and attach a statement listing all other parties and their contact

Employer or primary defendant

Address

Phone	Fax	Email

Defense Insurance

If multiple insurers are involved, list the lead insurer here and attach a statement listing all other parties and their contact information.

Is the defendant self-insured? ☐ Yes ☐ No

Primary contact, claim adjuster or claim handler		
Company		
Address		
Phone	Fax	Email

Defense Attorney

If multiple attorneys are involved, list the lead attorney here and attach a statement listing all other parties and their contact information.

Lead defense attorney		
Firm		
Address		
Phone	Fax	Email

Settlement

Has the claim settled? ☐ Yes ☐ No

If yes, what is the total amount of the settlement? _____

If no, what is the settlement offer, if any? _____

Insurance carrier policy limits

Is a copy of the draft or final settlement documents available? ☐ Yes ☐ No

Structure Broker

Name		
Company		
Address		
Phone	Fax	Email

Would you like our firm to recommend a structure broker? ☐ Yes ☐ No

Rated Ages / Life Expectancy

Have rated ages or life expectancy statements already been obtained in this matter? ☐ Yes ☐ No

If yes, please attach

If no, would you like our firm to obtain rated ages at no charge? ☐ Yes ☐ No

Special Notes

What to submit with a new referral:

Medical Records: At least for the past two years, detailing the injury, past and present treatment, and future physician recommendations. Please do not send originals. Include documents from Primary Care Physicians.

Future Medical Treatment Needs: Include any data that addresses these needs, such as deposition testimony, Life Care Plans, or treatment plans from Primary Care Physicians.

Medical Payment History: At least for the past two years, indicating at a minimum for each transaction the payee, the amount of payment or the amount billed, and the dates of service or the dates of payment.

Prescription Data: If no spreadsheet is available, then copies of current invoices may be used. For each prescription, the following must be given: drug name, dosage, pill count and refill frequency.

Indemnity and Expense Data: At least for the past two years, indicating for each transaction the payee, amount paid, and date of payment.

Cost Data: Any other data outlining costs spent or billed for the injury or illness. Examples include Explanation of Billing statements (EOB's), billing invoices, medical lien notices, or payment ledgers from insurance providers.

How to submit new referrals:

Electronic Submission: Email to joseph@hummelcs.com or christine@hummelcs.com
(Please limit attachments to a maximum of 20MB per email.)

Postal Service: Post Office Box 148, Ferdinand, Indiana 47532-0148

Delivery Services: Please contact us directly prior to shipping; thank you!

Facsimile: (978) 338-8116