

LUKS, SANTANIELLO,
 PETRILLO & JONES
 110 S. E. 6TH STREET – 20TH FLOOR
 FORT LAUDERDALE, FL 33301
 T: 954.761.9900 or F: 954.761.9940
 E-MAIL: **LS-MSP@LS-LAW.COM**

**LUKS, SANTANIELLO,
 PETRILLO & JONES**

SERVICE INTAKE FORM

(PLEASE PRINT AND MAIL OR E-MAIL COMPLETED DOCUMENTS.)

Today's date:						
CLAIMANT/PLAINTIFF INFORMATION						
Claimant/Plaintiff last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this the Claimant /Plaintiff's legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is the legal name?	(Former name): [REDACTED]		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:		Social Security no.:		Home phone no.: ()		
P.O. box:	City:	State:		ZIP Code:		
E-Mail:	Injury Date:			State of Jurisdiction.:		
Claim Number:	Guardian Appointed: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Defendant/Employer/Insured Name:						
Defendant/Employer/Insured Address:						
Please Indicate Case Type:		Service(s) Requested:		Comments Regarding Services Requested:		
<input type="checkbox"/> Workers' Compensation		<input type="checkbox"/> MSA				
<input type="checkbox"/> Liability		<input type="checkbox"/> MSA Submission & Approval				
<input type="checkbox"/> No-Fault Auto		<input type="checkbox"/> Future Medical Cost Projections				
		<input type="checkbox"/> MIR Reporting				

INSURANCE INFORMATION

Is Claimant/Plaintiff currently receiving Medicare Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know			
If Yes , please provide HICN #: _____			
Has Claimant/Plaintiff applied for/ been denied/and or appealing or receiving SS Disability Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know			
If Yes , please include supporting documentation.			
Date Medicare Eligible?	SSDI Beneficiary? <input type="checkbox"/> Yes <input type="checkbox"/> No	Mediation Date:	Settlement Agreement Total \$: _____ Medical \$: _____ Indemnity \$: _____

Workers' Compensation Claims Involved: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comparable negligence or apportionment of injuries found? <input type="checkbox"/> Yes <input type="checkbox"/> No	Settlement included funds for future medical care? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has claim been disputed based upon a "no liability" defense? <input type="checkbox"/> Yes <input type="checkbox"/> No Date Claim First Disputed: __/__/__
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For claims unsettled, please specify anticipated settlement range:

Has a rated age been obtained? Yes No If **Yes**, please include supporting documentation.

CONDITION OR CARE DISPUTED

Explain specific condition or care under dispute. Please include all legal & medical reasons as well as supporting documents/records to support denial of claim.

Claim Administration Company

Company Name:	Phone:
Contact Name:	Fax:
Address:	E-Mail:
City	State and Zip:

Insurance Company/Self Insured/State Fund

Company Name:	Phone:
Contact Name:	Fax:
Address:	E-Mail:
City	State and Zip:

Referral Contact & Billing Information

Company Name:	Phone:
Contact Name:	Fax:
Address:	E-Mail:
City	State and Zip:

Billing Information (IF Different from Referral).

Company Name:	Phone:
Contact Name:	Fax:

Address:	E-Mail:
City	State and Zip:
Attorney Information	
Defense Firm Name:	Phone:
Defense Counsel:	Fax:
Address:	E-Mail:
City	State and Zip:
Plaintiff Firm Name:	Phone:
Plaintiff Counsel:	Fax:
Address:	E-Mail:
City	State and Zip:
Structured Settlement Broker:	Phone:
Broker Contact:	Fax:
Address:	E-Mail:
City	State and Zip:
<p>Please include the following items with your completed form:</p> <p><input type="checkbox"/> Completed Service Request Registration Form.</p> <p><input type="checkbox"/> Initial notice of injury/police report/injury allegations/records from initial treatment.</p> <p><input type="checkbox"/> Printed medical and indemnity payment history with last 2 years history required for an MSA.</p> <p><input type="checkbox"/> All medical records.</p> <p><input type="checkbox"/> Medication and DME ledger history.</p> <p><input type="checkbox"/> Signed Medicare and SS Releases.</p> <p><input type="checkbox"/> Any rated ages obtained on life company letterhead.</p>	<p>PLEASE RETURN COMPLETED FORMS TO:</p> <p>LUKS, SANTANIELLO, PETRILLO & JONES DANIEL SANTANIELLO, MANAGING PARTNER 110 S. E. 6TH STREET – 20TH FLOOR FORT LAUDERDALE, FL 33301</p> <p>E-MAIL: LS-MSP@LS-LAW.COM T: 954.761.9900 or F: 954.761.9940</p>