THE LAW OFFICES OF
Seana B. Thomas

Medicare (MSP) Consultation and Case Management Retention Request
Initial Intake Information from Prospective Client

Section A	**Your Information**
Company:	
Examiner Name:	
Claim No.:	Date of Loss:
Accident Location:	
Description of Accident:	

Section B	**Plaintiff/Medicare Beneficiary**
Full Name (as it appears on Medicare card, if available):	
Sex: ☐ Male ☐ Female	
Complete Address:	
Phone: ( ) -	Date of Birth:
HICN:	SSN:
Description of injuries:	
Approximate Medical Specials:	

Section C	**Plaintiff Attorney (if represented at time of assignment)**
Name:	
Firm Name:	
Complete Firm Address:	
Firm Phone: ( ) -	Firm Fax: ( ) -
Attorney e-mail:	

Section D	**Defense Attorney (if assigned at time of assignment)**
Name:	
Firm Name:	
Complete Firm Address:	
Firm Phone: ( ) -	Firm Fax: ( ) -
Attorney e-mail:	

Section E	**Other Medicare Info:**
COBC Notified? ☐ Yes ☐ No (If yes, provide copy of notification)	
Special instructions/issues:	

	TO BE COMPLETED BY LAW OFFICES OF SEANA B. THOMAS
Date Retention Request Form Received by LOSBT:	
Date Conflict Check Performed:	
Result Conflict Check:	Date of Acknowledgment of Retention Request: