THE PLAINTIFF'S MSA AND LIEN SOLUTION LLC
PROTECTING PLAINTIFFS FROM MEDICARE ISSUES

AND

PRECISION RESOLUTION

To: Plaintiff's Trial Attorneys

RE: Medicare Conditional Payment (CP) Lien Resolution—Letter of Engagement

Dear Mr./Ms. Attorney:

So that we can best serve you, your firm and your client, we kindly ask that you give our office a call (**888-672-7583**) prior to the submission of the below intake forms so that we may address any general case questions you may have. This free, brief, upfront call will also afford us the opportunity to prepare a plan of action that is specific to your case so that once we receive the intake forms and relevant documents, we can get to work immediately. ***This short call and discussion is the best way we know of to prove our immediate value to you, without you risking a penny of your (or your client's) money.***

After our initial conversation**,** please complete the following steps and return the enclosed/attached documents to our office via email at liens@plaintiffsmsa.com or fax them to 503-406-2122.

Step 1: **New Case Intake Form (page 2) -** Please complete as precisely as possible. It helps us do our best work for your client, and eliminates a call to you or your staff;

Step 2: **CMS Proof of Representation Form: (page 3) -** To be signed by your client ("Beneficiary") and by you as the retained attorney (where it says: "Representative");

Step 3: Precision Resolution Proof of Representation Language (page 4) - To be copied or printed onto your own firm's letterhead and signed by you as the "Beneficiary's Attorney." Once the executed form is forwarded to Precision, our attorney representative will execute same**;**

Step 4: Review our Fee Schedule and Billing Policies (page 5) - Sending us a New Case Intake Form signifies your acceptance of such fees; and

Step 5: **Case Submission Fee** - Payment of the **Case Submission Fee in the amount of $750** is due, in entirety, prior to the commencement of any service rendered. Prepare a check made payable to **Precision Resolution, LLC and mail to the Plaintiff's MSA & Lien Solution address shown below.**

ADDITIONALLY, IF YOU HAVE RECEIVED ANY CORRESPONDENCE FROM CMS OR THE MSPRC RELATED TO THE SUBMITTED MATTER(S), PLEASE FORWARD ALL CORRESPONDENCES RECEIVED TO OUR ATTENTION WITH THE ABOVE-REFERENCED DOCUMENTS.

Upon our receipt of the above-required documents and retainer check, an email will be sent to your attention confirming receipt of the documents and check. Any invoices for the reduction of a lien amount negotiated will be forwarded to your attention at the time of resolution.

Thank you for your confidence in Plaintiff's MSA and Lien Solution and Precision Resolution. We look forward to providing you with a **PRECISION RESOLUTION**.

Best regards,

Jack L. Meligan, RSP, BCFE, MSCC, CMSP
The Plaintiff's MSA and Lien Solution, LLC
1800 Blankenship Rd., Ste. 160 West Linn, OR 97068
(T) 888-672-7583
(F) 503-406-2122

YOUR MEDICARE PROBLEM SOLVERS

PRECISION RESOLUTION

THE PLAINTIFF'S MSA AND LIEN SOLUTION LLC
PROTECTING PLAINTIFFS FROM MEDICARE ISSUES

New Case Intake Form

Referring Settlement Planner: The Plaintiff's MSA /SPI Home Ofc

Date of Request _____/_____/_____

So that Precision may begin processing your file immediately, please submit this completed form, along with any/all additional authorization forms to ***liens@plaintiffsmsa.com***

Attorney Information

Name _____

Phone _____ Fax _____

Firm _____

Address _____

City _____State _____ Zip _____

Attorney Email _____

Paralegal/Associate Contact _____

Paralegal/Associate Email _____

Claimant Information

Name _____

Gender ☐ Female ☐ Male

SSN _____ DOB _____/_____/_____

Address _____

City _____State _____ Zip _____

Phone _____

Has claimant lived in another state since date of injury? Yes* ☐ No ☐

*If yes, what state(s)? _____

Settlement Information

Has this case settled? ☐ Yes ☐ No Settlement Amount $_____

Settlement/Anticipated Settlement Date _____/_____/_____

Comments

Nature of Injury

DOI_____/_____/_____ DOD (if applicable) _____/_____/_____

Specific Nature of Accepted Injuries

Still Treating ☐ Yes ☐ No Last Treatment Date _____/_____/_____

Known Pre-Existing Conditions

Nature of Claim (check all that apply)

☐ Motor Vehicle Accident

NO-FAULT
No Fault Policy? ☐ Yes ☐ No
No Fault Carrier Full & Proper Name

APIP
Might APIP be Obligated to Pay Medicals? ☐ Yes ☐ No
APIP Carrier Full & Proper Name
Policy Limit $_____

☐ Medical Malpractice ☐ Exposure _____
☐ Nursing Home Negligence ☐ Product Liability _____
☐ Slip & Fall ☐ Other_____

LIABILITY
Liability Carrier Full & Proper Name
Policy Limit $_____

WORKERS' COMP
WC Carrier Full & Proper Name
Policy Limit $_____

OTHER BENEFITS RECEIVED

☐ Social Security Disability Insurance Start _____/_____/____ End _____/_____/____

☐ Supplemental Security Income Start _____/_____/____ End _____/_____/____

☐ Other _____ Start _____/_____/____ End _____/_____/____

Services Requested Check all that Apply		Claimant Receiving (Past or Present)	Case Reported to Agency	Relevant Claim Information
☐	Medicare Conditional Payment (Parts A/B)	☐	☐	HIC # _____ Entitlement Date _____/_____/_____
☐	Medicare Advantage (Parts C/D)	☐	☐	Insurance Company Name _____ Group/ID # _____
☐	Medicaid	☐	☐	Medicaid # _____ State(s) _____
☐	Self-Funded ERISA or Other Private Healthcare	☐	Plan Docs Requested? ○ *Yes ○ No	Insurance Company Name _____ Group/ID # _____ If Employer-based Health Plan, specify employer name _____ *Please provide Plan Document or Summary Plan Description if available.
☐	TRICARE	☐	☐	Treatment Facilities _____ Sponsor SSN_____
☐	Veteran's Administration	☐	☐	Treatment Facilities _____ Sponsor SSN_____

Relevant Claim Information
Please submit a copy of any/all correspondences with agency and claimant's insurance cards, along with this and all other authorization forms to liens@plaintiffsmsa.com or fax to 503-406-2122

Additional Comments

MSPRC

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

PROOF OF REPRESENTATION

The undersigned Medicare beneficiary informs the Centers for Medicare & Medicaid Services (CMS) that they have given the specified legal representative the authority to represent them and act on their behalf with respect to any claims for liability insurance, no-fault insurance, or workers compensation, including releasing identifiable health information or resolving any potential recovery claim that Medicare may have if there is a settlement, judgment, award, or other payment. The undersigned representative agrees that they represent the stated Medicare beneficiary.

Type of Representative:	**Authorized Representative:**
( ) Individual other than an Attorney: (X) Attorney ( ) Guardian* ( ) Conservator* ( ) Power of Attorney*	_____ (Attorney/ Law Firm Name) _____ (Law Firm Address) _____ (Law Firm City, State, Zip) _____ (Phone Number)

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

Medicare Beneficiary Information:

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

Beneficiary's Health Insurance Claim Number
(number on Medicare card): _____

Date of Illness/Injury **for which the beneficiary has filed a liability insurance, no-fault insurance or workers' compensation claim:** _____

Beneficiary's Signature: _____ Date signed: _____

Representative's Signature: _____ Date signed: _____

(Attorney)

Medicare Secondary Payer Recovery Contractor
MSPRC-NGHP
Post Office Box 138832
Oklahoma City, OK 73113

Date:

PRECISION RESOLUTION, LLC
PROOF OF REPRESENTATION

RE: **Beneficiary:**
HIC#:
Date of Incident:

Dear Sir or Madam:

Please be advised that **,** the attorney for the above referenced Medicare beneficiary, has appointed **Precision Resolution**, **LLC** as representative regarding the resolution of any Medicare conditional payment issues pertaining to this file. Please provide **Precision Resolution, LLC** with any information regarding this claim to the following address:

Precision Resolution, LLC
4134 Seneca Street
Buffalo, NY 14224

Signature of Beneficiary's Attorney: _____

Date:

Representative's Signature: _____
Paul R. Loudenslager, Esq.
Precision Resolution, LLC

Date:

PRECISION RESOLUTION

Medicare Conditional Payments and Medicare Lien Resolution

Fee Schedule

Service	Fee	Fees Due to PR
Opening, Tracking, Challenge and Closing of Medicare File	$750.00	Upon Submission of Intake and Authorization Forms to Precision
	plus, in the event of a successful challenge:	
Successful Challenge Resulting in a Reduction of Lien Amount	15% of Reduction with a $5,750.00 cap on fees for all services rendered*	Payment for the reduction of a lien amount resulting from a challenge filed by Precision shall be due at the time of Medicare's (or other governing body's) decision.

*This fee applies to reductions of the lien amount as a result from a formal challenge of a lien. Medicare's standard reductions for attorney'sfees and procurement costs, etc. is not a billable service rendered by Precision. Appeals made to an Administrative Law Judge would bebilled at an additional cost of $200.00 an hour, plus 25% of the reduction of the lien amount.

Please make all checks payable to Precision Resolution, LLC
and mail all checks for services rendered, with the case name in the memo line, to:

Precision Resolution, LLC
c/o Plaintiff's MSA & Lien Solution, LLC
1800 Blankenship Rd., Ste. 160
West Linn, OR 97068

Upon receipt of the payment, Precision will forward a paid invoice to your attention **and begin work on the file**.

Please direct any billing specific questions to billing@precisionlienresolution.com.

Precision Resolution, LLC Tax ID: 27-4860890

Always demand Precision.