MEDIVEST

Professional Administration Referral Form

Please send form and documentation to:
12226 Corporate Blvd., Ste. 142-322, Orlando, FL 32817
Phone: 877.725.2467 Fax: 407.971.4742
www.medivest.com

Requested Service

- ☐ Professional Administration
  - ☐ MSA (Medicare Allowable portion)
  - ☐ MCA (Non-Medicare Allowable portion)
  - ☐ MCA-O (Open Medical Component)
- ☐ Trust Advisor Service
- ☐ Self-Administration Kit

☐ Workers' Compensation ☐ Liability ☐ Other _____

Claimant/Applicant Information

Claimant/Applicant Full Name				Referral Date (mm/dd/yy)
Claimant/Applicant Telephone Number	Gender (M/F)	Date of Birth (mm/dd/yy)	Social Security #	Jurisdiction State
Claimant/Applicant Address	City	State	Zip Code	
Injury #1 Brief Description — Continuous Trauma ☐	Injury #1 Date(s)	Injury #1 Claim Number		
Injury #2 Brief Description — Continuous Trauma ☐	Injury #2 Date(s)	Injury #2 Claim Number		

Account Reversion Information

☐ Upon death, the account is reversionary to a designated beneficiary. _____ % Reversionary to designated beneficiary

☐ Upon death, the account is reversionary to the Payor. _____ % Reversionary to the Payor

Designated Beneficiary Information

Beneficiary Full Name	Social Security #	Beneficiary Address		
Relation to Claimant/Applicant	Date of Birth (mm/dd/yy)	City	State	Zip Code

Contact / Billing Information

Send Agreement to: ☐ Adjuster ☐ Defense Attorney ☐ Plaintiff Attorney ☐ Broker ☐ Claimant/Applicant ☐ Other: _____

Party Responsible for Invoice: ☐ Adjuster ☐ Defense Attorney ☐ Plaintiff Attorney ☐ Broker ☐ Claimant/Applicant ☐ Other: _____

Adjuster (or Trustee, for Trust Advisor Services) **Name**		Company			Referring Party ☐
Telephone Number	Fax Number	Email Address			
Address		City	State	Zip Code	

Defense Attorney Name		Company			Referring Party ☐
Telephone Number	Fax Number	Email Address			
Address		City	State	Zip Code	

Plaintiff Attorney Name		Company			Referring Party ☐
Telephone Number	Fax Number	Email Address			
Address		City	State	Zip Code	

Structured Settlement Broker Name		Company			Referring Party ☐
Telephone Number	Fax Number	Email Address			
Address		City	State	Zip Code	