FORTIS
settlement solutions

Referral Form

Send the completed referral form to info@fortismsp.com

Assignment
Select Assignment Type

Employer Name

Jurisdiction
Select State

Carrier

Is Claim in Excess? Yes ◯ No ◯

Accepted Diagnoses

Companion Claims? Yes ◯ No ◯

If Yes, include DOA, Claim# and WCB# (if applicable) in special instructions box.

Claim #

DOA

WCB#

Special Instructions

Estimated Settlement Amount

MSA Done Previously? Yes ◯ No ◯ If Yes, please attach report

Has Indemnity Settled? Yes ◯ No ◯

Indemnity Amount

Examiner

Organization | **First Name** | **Last Name** | **Phone** | **Email**

Address 1 | **Address 2** | **City** | **State** (Select State) | **Postal Code**

Type of Claim
Select Claim Type

Claimant Social Security Disability Status
Select Disability Status

Medicare Eligible Yes ◯ No ◯

Claimant

First Name | **Last Name** | **Phone** | **Email** | **Date of Birth** | **Soc. Sec. #**

Address 1 | **Address 2** | **City** | **State** (Select State) | **Postal Code**

Claimant Attorney

May we contact claimant attorney regarding form and discovery? Yes ◯ No ◯

Firm Name | **First Name** | **Last Name** | **Phone** | **Email**

Address 1 | **Address 2** | **City** | **State** (Select State) | **Postal Code**

Defense Attorney

May we contact defense attorney regarding this assignment? Yes ◯ No ◯

Firm Name | **First Name** | **Last Name** | **Phone** | **Email**

Address 1 | **Address 2** | **City** | **State** (Select State) | **Postal Code**