

Case Intake Form

Fax to
706-856-2537

Email to
intake@forgeconsulting.com

Plaintiff Attorney

CASE TYPE PI MedMal MVA WC WD Other

PLAINTIFF ATTORNEY NAME	PLAINTIFF ATTORNEY PHONE NUMBER	PLAINTIFF ATTORNEY FAX NUMBER	
PLAINTIFF ATTORNEY EMAIL	PLAINTIFF ATTORNEY FIRM NAME		
ASSISTANT/PARALEGAL NAME	ASSISTANT/PARALEGAL EMAIL		
PLAINTIFF ATTORNEY ADDRESS	CITY	STATE	ZIP CODE

Defendant & Insurer

DEFENSE ATTORNEY NAME	DEFENSE PHONE NUMBER	OKAY TO CONTACT DEFENSE? <input type="radio"/> Yes <input type="radio"/> No	
DEFENSE ADDRESS	DEFENSE FIRM NAME		
INSURER CARRIER/ADJUSTER	INSURANCE CLAIM NUMBER	INSURANCE PHONE NUMBER	INSURANCE FAX NUMBER
INSURANCE ADDRESS	CITY	STATE	ZIP CODE
			INSURANCE EMAIL

Case Details

Please fax or email case caption and case original complaint

DATE OF LOSS	STATE OF JURISDICTION	PROJECTED INJURY-RELATED EXPENSES	If applicable, please fax or email 15–20 pages of the most recent medical records (IMEs, Discharge Summaries) and any expert report (Life Care Plan, Economist Report, Loss of earning report, MSA Allocation, etc.)
DESCRIPTION OF INJURY			

Claimant

Please fax or email a copy of each claimant's birth certificate

CLAIMANT NAME	CLAIMANT D.O.B.	CLAIMANT SEX <input type="radio"/> Male <input type="radio"/> Female	CLAIMANT SOCIAL SECURITY NUMBER
CLAIMANT ADDRESS		CITY	STATE ZIP CODE
CLAIMANT EMAIL		CLAIMANT PHONE NUMBER	ALTERNATE PHONE NUMBER
CONTACT PERSON NAME (IF OTHER THAN CLAIMANT)		CONTACT PERSON PHONE NUMBER	
ADDITIONAL CLAIMANT NAME	ADD. CLAIMANT D.O.B.	ADD. CLAIMANT SEX <input type="radio"/> Male <input type="radio"/> Female	ADD. CLAIMANT SOCIAL SECURITY NUMBER
ADDITIONAL CLAIMANT NAME	ADD. CLAIMANT D.O.B.	ADD. CLAIMANT SEX <input type="radio"/> Male <input type="radio"/> Female	ADD. CLAIMANT SOCIAL SECURITY NUMBER

If there are more claimants than this form allows for, please attach on a separate page.

Benefits & Entitlements

RECEIVING MEDICAID <input type="radio"/> Yes <input type="radio"/> No	STATE	RECEIVING S.S.I. <input type="radio"/> Yes <input type="radio"/> No	S.S.I. MONTHLY AMOUNT	RECEIVING S.S.D.I. <input type="radio"/> Yes <input type="radio"/> No	S.S.D.I. MONTHLY AMOUNT
RECEIVING MEDICARE <input type="radio"/> Yes <input type="radio"/> No	MEDICARE PLAN <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D	MEDICARE ENTITLEMENT DATE	RECEIVING WORKERS' COMP BENEFITS <input type="radio"/> Yes <input type="radio"/> No	Please select Yes if claimant is receiving or has applied for workers' compensation benefits	
PRIVATE HEALTH INSURANCE <input type="radio"/> Yes <input type="radio"/> No	OTHER (PLEASE DESCRIBE) <input type="radio"/> Yes <input type="radio"/> No				

Settlement Details

IMPORTANT When a structured settlement is a consideration for a case, no settlement proceeds should be accepted by plaintiffs or the plaintiffs' attorneys directly prior to deciding on amount to structure. The defendant and/or defendant's insurer must issue a premium check directly to the life insurance company to fund the structured settlement. Additionally, there will be required language for the Release, and Petition & Order (Minors Settlement), and an Assigned Document.

HAS CASE SETTLED? <input type="radio"/> Yes <input type="radio"/> No	ACTUAL/PROJECTED SETTLEMENT DATE	COURT DATE	ACTUAL/PROJECTED GROSS RECOVERY	ACTUAL/PROJECTED %
EXPENSES	ACTUAL/PROJECTED NET PROCEEDS	ACTUAL/PROJECTED ECONOMIC DAMAGES	ACTUAL/PROJECTED NON-ECONOMIC DAMAGES	

Services

Please indicate which services are needed for this case

- Structured Settlement Annuity
 Present Value Analysis
 Special Needs Trust
 Conservatorship
 Attorney Fee Structure
 Minors Settlement
 Medicare Set-Aside Allocation
 Other:

