



Settlement Demand Preparation Intake Form Medical Malpractice

Law Firm:		Client/Case Name:	
Contact Person/Number:		Age:	DOB:
Date of Injury:	Date Sent to CLS:	Deadline:	
Brief Description of Incident and Type of Injury:			
Second, Corrective Surgery Required:		Permanent Injury:	
YES	NO	YES	NO
Incident Report:		Plaintiff's Deposition Taken:	
YES	NO	YES	NO
Date of Death (if applicable):		Wage Loss:	
		YES	NO
Medical and Billing Records:			
HAVE		NEED TO OBTAIN	
Healthcare Provider Information:			
Medicare:	YES	NO	
Medicaid:	YES	NO	
Private Insurance:	YES	NO	If Yes, Provider Name: _____
Tri-Care/VA Coverage:	YES	NO	If Yes, Provider Name: _____
Other Coverage:	YES	NO	If Yes, Provider Name: _____



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Document Checklist

- Complaint
- Answers to interrogatories (Plaintiff and Defendant)
- Incident Report
- Hospital/ER records
- Primary Care Physician records
- Additional treating physician records
- Medical bills from all treating facilities
- Documentation of out-of-pocket expenses
- Employment records for wage loss verification
- Functional assessment evaluation (if applicable)
- Copy of Death Certificate (if applicable)
- Medical examiner evaluation report/Autopsy report (if applicable)

Optional Records (may be beneficial depending on case)

- Funeral expenses (if applicable)

Medical Records Analysis Disclosure: After review of medical records received to date, further medical record retrieval may be necessary in order to complete full medical case analysis. A summary of the records required will be forwarded for your review and retrieval will begin upon your authorization. Additional record retrieval fees will apply to amended retrieval efforts.

Completed By: _____ Date: _____