

GUARANTEED LIENS

Lien Resolution Services – Referral Form

Please complete all fields and return to info@guaranteedliens.com

CLIENT / REFERRAL INFORMATION

Law Firm / Company Name:

Referred By:

Contact Phone #:

Contact Email Address:

Contact Mailing Address:

CLAIMANT INFORMATION

Claimant Full Name:

Claimant Complete Address:

Social Security #:

Medicare #:

Date of Birth:

CASE INFORMATION

Claim #:

Date of Injury:

Type of Accident (MVA, slip & fall, products liability, W/C, etc.):

Carrier Name (if known):

Carrier Address:

Adjuster Name (if known):

Adjuster Phone #:

Adjuster Email:

Description of Claimed Injury:

Miscellaneous Information:

TYPE OF LIEN (check all that apply)

Medicaid

Medicare

ERISA / Private Health Plan

VA