MASSIVE Client Intake Form

Submit at **www.goMASSIVE.com** *OR* email to **info@goMASSIVE.com**

Injured Person/Claimant Information

Your File #: _____
Claimant: _____
SSN: _____
DOB: _____
Address: _____
City/St./Zip: _____
Date of Death (if applicable): _____
Guardian or Other Power of Attorney:
_____
Please attach legal documents authorizing the above-named person

Plaintiff's email for DocuSign (If applicable):
_____

Law Firm Information

Firm Contact: _____
Email: _____
Additional Firm Contact: _____
Email: _____

Injury Information

Date of Injury: _____
Event: _____
Injuries: _____
_____
Preexisting Conditions: _____
_____
Last Date of Treatment: _____

Case Status: _____
If Settled, Settlement Date: _____
Settlement Type: _____
Settlement Amount: _____
☐ Partial ☐ Full
Attorney Fees: $ _____
Case Expenses: $_____

Additional Case Notes: _____
_____
_____

PIP, Med-Pay, or No-Fault Insurance
(If applicable)

Do you represent the Plaintiff for this? _____
Insurer: _____
Address: _____
Claim #: _____
Adj. Name/Phone: _____
Policy Limits (if any): _____

Defendant (Liability) Insurance

Do you represent the Plaintiff for this? _____
Insurer: _____
Address: _____
Claim #: _____
Adj. Name/Phone: _____
Policy Limits (if any): _____

Health Insurance Information

List *only* the insurers/potential liens you want MASSIVE to resolve

Medicare A/B # _____
Have you contacted the above insurer? ☐ Yes ☐ No

Medicare C/D (Advantage/Supplement)
Insurer Name: _____
Have you contacted the above insurer? ☐ Yes ☐ No

Medicaid # _____
State and/or Program Name: _____
Have you contacted the above insurer? ☐ Yes ☐ No

PLEASE ATTACH INSURANCE CARDS IF AVAILABLE

Private Health / ERISA
Insurer Name: _____
Employer: _____
Have you contacted the above insurer? ☐ Yes ☐ No

Additional Insurance, Medicaid, etc.
Insurer Name: _____
Employer: _____
Have you contacted the above insurer? ☐ Yes ☐ No

Military Health: TriCare OR VA Hospital (Please circle)
Sponsor Name & SSN: _____
Have you contacted the above insurer? ☐ Yes ☐ No