

Lien Case Information

Name: _____
Last First M.I. Gender

Address: _____
Street Address City State Zip Code

Phone: _____ Date of Birth: _____ Social Security Number: _____

Lien Information

Medicare: Yes No If yes, Medicare Number: _____
 Medicaid: Yes No If yes, Medicaid Number: _____
 Private Insurance: Yes No If yes, provider name and phone: _____
 Tri-Care/VA Coverage: Yes No If yes, provider name and phone: _____
 Other Coverage: Yes No If yes, provider name and phone: _____

Accident/Injury Information

Type of Case: Workers Comp. Liability Description of Accident: _____
 Case Jurisdiction (State): _____ Date of Accident: _____
 Description of Injury: _____
 Pre-existing Conditions: _____
 Has the case settled: Yes No Date of Settlement: _____ Gross Settlement Amount: _____

Public Benefit Information

Is the claimant expected to receive, or currently receiving any of the following benefits?

Social Security Retirement (SSR) or Disability (SSDI) Yes No Expected
 Supplemental Security Income (SSI) Yes No Expected
 Medicaid Yes No Expected

Referring Party or Law Firm

Name: _____ Phone: _____ Email: _____
 Firm Name: _____
 Address: _____
 Firm Contact: _____ Email: _____

Warranty

The above information is being provided to The Center for Lien Resolution, LLC (The Center) for the purpose of verifying and/or resolving one or more healthcare liens. I hereby affirm and warrant by my signature that all of the information herein is accurate and complete to the best of my understanding. I further affirm and agree that I shall hold The Center harmless and indemnify it from any detrimental result that may occur from its reliance on any information provided by me that may later prove to be inaccurate or incorrect.

Signature: _____ Date: _____

Proof of Representation

This Proof of Representation form follows the model language that has been suggested by the Centers for Medicare and Medicaid Services (CMS). A signed copy of the form must be submitted to CMS whenever a Medicare beneficiary wants to inform CMS that they have given another individual the authority to represent them and act on their behalf with respect to their claim for liability insurance, no-fault insurance, or workers' compensation, including releasing identifiable health information or resolving any potential recovery claim that Medicare may have if there is a settlement, judgment, award, or other payment. Since the Center for Lien Resolution (the Center) must also sign this form, the appropriate person at the Center will sign and date the last line below after you return your completed and signed form to us.

Representative Type:

Individual other than an Attorney: Name: _____
 Attorney Relationship to Medicare Beneficiary: _____
 Guardian Firm or Company Name: **The Center for Lien Resolution, LLC**
 Conservator Address: **4912 Creekside Drive**
 Power of Attorney **Clearwater, FL 33760**
Telephone: **727-471-1850**

Medicare Beneficiary Information/Signature:

Beneficiary's Name (please print exactly as shown on your Medicare card): _____

Beneficiary's Health Insurance Claim Number (number on your Medicare card): _____

Date of illness/injury for which the beneficiary has filed a liability insurance, no-fault insurance or workers' compensation claim: _____

Beneficiary's Signature: _____ Date: _____

Representative Signature (The Center for Lien Resolution Representative's signature below):

Representative's Signature _____ Date : _____

CMS Consent to Release Form

I, _____, authorize The Center for Medicare and Medicaid Services (CMS), its agents and/or contractors to release any and all records to the person or entity below.

The Center for Lien Resolution, LLC
4912 Creekside Drive
Clearwater, FL 33760
727-471-1850

By completing and signing this consent form, I recognize and acknowledge that this consent: a) is for release of information purposes only and will have no affect on any benefits to which I may be entitled under the Medicare and/or Medicaid Program; b) allows the release of Medicare and Medicaid claims and other information related to my injury and/or illness; and, c) authorizes the release of information to the person(s) named above upon their request and that any such released information may be re-disclosed by them and may no longer be protected by law.

I further understand that I have the right to revoke my consent and authorization at any time in writing, except to the extent that CMS has already taken action in reliance thereof. If not previously revoked by me, this consent will terminate automatically when all claims, if any, have been resolved and all Medicare Secondary Payer files have been closed.

Claimant/Legal Representative Signature

Date

Date of Injury/Accident

Medicare Number

If signed by your legal representative, a copy of the documents authorizing your representative to act for you must be attached to this consent. Examples of such documents would include a Durable Power of Attorney, Letters of Guardianship/Conservatorship, or any other document that establishes your representative's authority.

PRIVACY STATEMENT

The information to be collected in regard to this consent will be used in furtherance of, and to comply with, Section 1862(b) of the Social Security Act (42 U.S.C. 1395y). This information will be used to determine whether any medical services received are covered by Medicare or Medicaid, or whether a no-fault, automobile, liability insurer, or any other person(s) may be responsible for such payment.

A photocopy or facsimile of this Consent to Release form shall be valid and given the same force and effect as the original.



For Lien Resolution

HIPAA COMPLIANT AUTHORIZATION

Authorization for the Use and Disclosure of Protected Health Information

1. Personal Information:

Name: _____ Birth Date: _____

ID Number: _____ OR Social Security Number: _____

2. I give permission to _____ (hereafter "Entity") and its contract representatives to share the health information listed below with the following:

The Center for Lien Resolution, LLC
4912 Creekside Drive
Clearwater, FL 33760
727-471-1850

3. Indicate the purpose for which the disclosure is to be made:

To substantiate claim relating to a lawsuit or claim
 Other

4. Indicate the information that you want to be disclosed, related to the following:

Any and All records requested.

5. Enter the specific date that you want this authorization to expire: (i.e., one year from date of release) _____ (If you do not enter a date, this authorization will expire in five years.)

I understand that the information described above may be redisclosed by the person or group that I hereby give Entity, its employees, and its agents permission to share my information with, and that my information would no longer be protected by the federal privacy regulations. Therefore, I release Entity, its employees, and its agents from all liability arising from the disclosure of my health information pursuant to this authorization. I understand that I may inspect or request copies of any information disclosed by this authorization if Entity, its employees, or its agents required the submission of this HIPAA Authorization in order to release information. I understand that I may revoke this authorization by notifying Entity through its employees and/or agents, in writing, knowing that previously disclosed information would not be subject to my revocation request. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or eligibility for benefits.

6. Print Name _____ Date _____

Signature _____

Or (please provide a copy of your letters of guardianship or conservatorship, durable power of attorney, etc., if applicable)

Name of Legal Representative (Print) _____

Relationship _____

Signature of Legal Representative _____ Date _____