PROOF OF REPRESENTATION

The language below should be used when you, the Medicare beneficiary, want to inform the Centers for Medicare & Medicaid Services (CMS) that you have given another individual the authority to represent you and act on your behalf with respect to your 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. You are not required to use this model language, but proof of representation must include the information provided in this model language. Your representative must also sign that he/she has agreed to represent you. This model language also makes provisions for the information your representative must provide.

Type of Medicare Beneficiary Representative (Check one below and then print the requested information)**:**

( )	Individual other than an Attorney:	Name: _____
( )	Attorney*	Relationship to the Medicare Beneficiary: _____
( )	Guardian*	Firm or Company Name: _____
( )	Conservator*	Address: _____
( )	Power of Attorney*	_____
		_____
		Telephone: _____

* Note -- If you have an attorney, your attorney may be able to use his/her retainer agreement instead of this language. (If the beneficiary is incapacitated, his/her guardian, conservator, power of attorney etc. will need to submit documentation other than this model language.) Please visit www.msprc.info for further instructions.

Medicare Beneficiary Information and Signature/Date:

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 Signature: _____ Date signed: _____

Representative Signature/Date:

Representative's Signature: _____ Date signed: _____

PATIENT AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI) (HIPAA Compliant)

I, _____ , hereby authorize the use or disclosure of my Protected Health Information that is described below, to Providio MediSolutions and its agents, at 5613 DTC Parkway, Suite 600, Greenwood Village, CO 80111.

The provider (Physicians, health care providers and payers, my employer, Centers for Medicare and Medicaid Services, Social Security Administration) are directed to make available, all of my medical records, including, but not limited to records regarding treatment, hospitalizations, evaluations, testing and surgeries, if requested. Permission is also granted to discuss and share this pertinent medical and health care information with professionals involved to complete a Medicare Set-Aside Allocation. Additional information to be disclosed by the provider if the pertinent box below is checked:

- ☐ All billing records showing all charges, expenses, costs and payments.
- ☐ X-ray films, MRI films and other radiological films.
- ☐ Drug and alcohol abuse testing, evaluation and treatment.
- ☐ Mental health information, consisting of, but not limited to all notes, records and reports of psychotherapy, diagnosis, evaluation and treatment.
- ☐ Information regarding human immune deficiency virus (HIV) or acquired immune deficiency syndrome (AIDS).

At my request, this information will be used for the purpose of assisting the designated representative of Medicare Allocations, Inc. in completing a Medicare Set-aside Allocation.

This Authorization may be revoked at any time by giving written notice to the healthcare provider of revocation of the Authorization. I have the right to refuse to sign this document. Upon request, I have the right to a copy of this authorization.

I understand that I have the right to refuse to sign this Authorization and that the healthcare provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

I understand that once PHI is disclosed, it may be re-disclosed to individuals or organizations that are not subject to the federal privacy regulations such as expert witnesses, litigants, insurance companies and even may become public record if filed with a court of law.

If necessary, a reproduction of this agreement may be used in lieu of the original.

This authorization will expire 2 years after the date of signing.

DATED this _____ day of _____, 20____.

Name: _____
Date of Birth: _____
Social Security No.: _____
Medicare No.: _____

CONSENT TO RELEASE FORM

The Privacy Act of 1974 (Public Law 93-579) prohibits the government from revealing information from personal files without the express written permission of the person involved. Disclosure of personal records to an attorney or other representative who is acting on behalf of another person is prohibited, unless the individual to whom the record pertains has consented.

I, , hereby authorize the Centers for Medicare & Medicaid Services (CMS), its agents and/or contractors to disclose, discuss, and/or release, orally or in writing, information related to my worker's compensation injury and/or settlement to the individual(s) and/or firm(s) listed below. This consent is for my current workers' compensation claim and is on an ongoing basis. An additional consent to release form will not be necessary unless or until I revoke this authorization (which must be in writing).

PLEASE CHECK:

( )	Claimant's attorney	_____ (name and/or firm)
( )	Employer's attorney	_____ (name and/or firm)
( )	Workers' Compensation carrier	_____ (name and/or firm)
( )	Other	Providio MediSolutions, LLC
( )	Other	John J. Campbell, CELA Law Office of John J. Campbell, P.C.

_____ _____

Claimant's Signature Date Signed

_____ _____

Date of Injury Social Security Number Or
Health Insurance Claim Number

Social Security Administration | Form Approved

Consent for Release of Information

OMB. No. 0960-0566

*SSA will not honor this form unless all required fields have been completed (*signifies required field).*

TO: Social Security Administration

*Name	*Date of Birth	*Social Security Number

I authorize the Social Security Administration to release information or records about me to:

*NAME	*ADDRESS
Providio MediSolutions, Inc.	5613 DTC Parkway, Suite 600
(877) 253-3120	Greenwood Village, CO 80111

* I want this information released because: To establish my Social Security Disability status, date of entitlement to Medicare, and the basis for Medicare entitlement (disability or age) for the purposes of my Workers' Compensation or Liability claim.

**There may be a charge for releasing information **

*Please release the following information selected from the list below:
You must check at least one box. Also, SSA will not disclose records unless applicable date ranges are included

- ☐ Social Security Number
- ☐ Current monthly Social Security benefit amount
- ☐ Current monthly Supplemental Security Income payment amount
- ☐ My benefits/payments amounts from _____to _____
- ☐ My Medicare entitlement from _____to _____
- ☐ Medical Records from my claims folder(s) from _____to _____
  If you want SSA to release a minor's medical records, do not use this form but instead contact your local SSA office.
- ☐ Complete medical records from my claims folder(s)
- ☑ Other record(s) from my file (e.g. applications, questionnaires, consultative examination reports, determinations, etc.) Medicare Health Insurance Claim 4* (HICN#), SSDI entitlement date, Medicare Parts A& B entitlement dates, Date applied for Disability Benefits, Date SSDI payments started, current SSDI payment status, and current SSDI payment amount.

  This information may be faxed to Providio MediSolutions, LLC at (866) 862-3628.

*Providio MediSolutions, LLC. responsible party for any charges associated with release of this information.

I am the individual to whom the requested information/record applies, or the parent or legal guardian of a minor or the legal guardian of a legally incompetent adult. I declare under penalty of perjury in accordance with 28 C.F.R. §16.41(d)(2004) that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that any applicable fees must be paid by me.

*Signature: _____ *Date: _____

Relationship *(if not the individual)*: _____ *Daytime Phone: _____