Medicare Conditional Payment Request

You have requested my office be engaged to investigate and/or reconcile Medicare conditional payment information. I am requesting the following services be provided (check all that apply). By signing below you are accepting responsibility for payment of all fees. All Fees are prepaid.

Scope of Service	**Fee**
☐ Commencing Medicare conditional payment notice of claim; securing preliminary conditional payment letter with Payment Summary Form:	$350.00
☐ Submission of Final Settlement Detail Document *without* reconciliation of Payment Summary Form entries; Securing Final Demand Letter:	$395.00
☐ Reconciliation of Payment Summary Form entries; submission of Final Settlement Detail Document; Securing Final Demand Letter:	$975.00
Please note that if reconciliation services are requested you will need to provide my office with the last two years medical reports and billing records including ICD-9 billing codes.	
☐ Appeals of disputed payment summary form entries beyond administrative MSPRC level (Administrative Law Judge) will require a retainer of $1250 and will be billed at an hourly rate of $395.00. Appeals are not automatically filed by my office and require a separate Retainer agreement be mutually agreed upon.	$1250/$395

The following forms need to be completed and returned along with the applicable prepaid fee(s) to Angelo Paul Sevarino, Esq., 26 Barber Hill Road, Broad Brook, CT 06016.

1. Specific Case Information form.

2. Proof of Representation form (if notice, receipt of CPL, review and reconciliation IS being requested).

3. Consent to Release form (if *only* notice and receipt of CPL is being requested

4. Final Settlement Detail Document (only if case has settled)

5. Provide a copy of your client's Medicare Card

6. If applicable provide the Medicare beneficiary's password for the "myMedicare.gov" Password:_____

_____ Date:_____

Authorized Representative Signature

Specific Case Information

Claimant/Plaintiff:
Name:
Address:
SSN/HICN:
Telephone Number:
Gender:

Claimant/Plaintiff's Attorney
Name:
Address:
Telephone Number:

Employer(WC) or Defendant (Liability) (if multiple employers/defendants list on separate sheet)
Name:
Address:
Telephone Number:

Insurer(if multiple insurers list on separate sheet; indicate related employer/defendant)
Name:
Address:
Claim Number:

Insurer's Attorney(if multiple counsel list on separate sheet, indicate related insurer)
Name:
Address:
Telephone Number:

Medicare Coverage Parts (check all that apply)**:**

☐ Claimant is NOT on Medicare ☐ Claimant IS on Medicare Part A: ☐ B:☐ C:☐ D: ☐

Date of Injury:

Claimant's Date of Birth:

Body Part(s)/System(s) that are being claimed (be specific)

Total Gross Settlement Amount: $ **☐ Not yet determined but estimated to be: $**

Comments/Special Instructions:

PROOF OF REPRESENTATION

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

■ Attorney other than an Attorney of record: Name: Angelo Paul Severino, Esq.
Address: 26 Barber Hill Road,
Broad Brook, CT 06016
Telephone: 860-870-3803

☐ Attorney Relationship to the Medicare Beneficiary:

☐ Guardian/Conservator Name: _____
Address: _____
Telephone: _____

☐ Power of Attorney Name: _____
Address: _____
Telephone: _____

Medicare Beneficiary Information and Signature/Date:

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

_____

Beneficiary's Health Insurance Claim Number (number on 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's Signature: _____ Date signed: _____
Angelo Paul Severino

CONSENT TO RELEASE FORM

I, _____ hereby authorize The Centers for Medicare & Medicaid Services
(Print Name)
(CMS), its agents and/or contractors to release, upon request, information related to my injury/illness

and/or settlement for the specified date of injury/illness to the individual and/or entity listed below:

CHECK ONLY ONE OF THE FOLLOWING TO INDICATE WHO MAY RECEIVE INFORMATION AND THEN PRINT THE REQUESTED INFORMATION:

(If you intend to have your information released to more than one individual or entity, you must complete a separate release for each one.)

( ) Workers' Compensation Carrier ( ) Liability Carrier ( ) My Attorney
(X) Other: Submitter

Name of Individual/Entity: Angelo Paul Sevarino, Esq.

Address: 26 Barber Hill Road Broad Brook, CT 06016

Telephone: 860-870-3803
Fax: 860-870-3805

INDICATE HOW LONG CMS MAY RELEASE YOUR INFORMATION (The period you check will run from when you sign the date below)

(X) One Year ( ) Two Years ( ) Other_____
(Provide a specific period of time)

I understand that I may revoke this "consent to release information" at any time, in writing.

MEDICARE BENEFICIARY INFORMATION AND SIGNATURE

Claimant Signature: _____ Date Signed: _____

Note: If the Claimant is incapacitated, the submitter of this document will need to include documentation establishing the authority of the individual signing on the Claimant's behalf. Please visit www.msprc.info for further instructions.

Medicare Health Insurance Claim Number (The number as shown on your Medicare card):

❑❑❑-❑❑-❑❑❑❑-❑❑

Date of Injury/Illness:_____

Authorization for Release of Protected Health Information

(In compliance with HIPAA Regulations - 45 C.F.R. 164.508)

To:

RE: SNN#: Date of Birth:

I authorize the use or disclosure of my protected health information by your office, company or organization as specified below. I understand that signing this Authorization is voluntary and that my medical provider may not require me to sign this Authorization before my doctor, hospital or institution provides me with treatment. I understand that I have the right to revoke this Authorization at any time by providing a signed, written notice of such revocation to my medical provider. I understand that a description of my right to revoke my Authorization is set forth in my medical provider's Notice of Privacy Practices. I understand that information is being released pursuant to this Authorization at my request and that the information may no longer be protected by law or regulation and may be redisclosed by the recipient.

1. a. Please use or disclose the following health information if such information exists:
   - ☐ The entire medical record; or
   - ☐ The following limited health information:

b. Your medical institution/provider cannot use or disclose certain information unless you specifically authorize such use or disclosure. **Please initial next to each item below if you specifically authorize the release** of health information relating to the testing, diagnosis or treatment for:

___ HIV/AIDS
___ Drug and alcohol abuse
___ Mental health/psychiatric disorders

2. Please specify the time period for the information you described above to be disclosed:

   - ☐ All information maintained at any time by my medical provider or
   - ☐ Information maintained by my medical provider from __/__/__ to __/__/__

3. Please specify who may receive the information requested by this authorization:

   Angelo Paul Sevarino, Esq., 26 Barber Hill Road, Broad Brook, CT 06016 (860-870-3803)

Unless earlier revoked, this authorization will expire one year from the date signed below, unless you specify an earlier date here: __/__/__.

By signing below, I understand and acknowledge the following:

I have read and understand this Authorization;
I am authorizing my medical provider to use or disclose the health information to the person(s) and for the purpose(s) identified in this authorization; and
If I have any questions about disclosure of my protected health information pursuant to this Authorization, I may contact my medical provider's Privacy Officer.

A photostatic copy of this Authorization shall be considered as effective and valid as the original.

_____ _____

Name of Individual

Signature of Patient/Client or Personal Representative

Date:_____

If signed by the Patient's/Client's personal representative, describe the legal authority of the representative to act on behalf of the Patient/Client._____.

Legal authority of representative verified by:_____