Medicare Conditional Payment Request

If the Claimant is currently a Medicare beneficiary or has been a Medicare beneficiary in the past my office provides complete Medicare Secondary Payer compliance including those services listed below.

Please note this service *does not include* reconciliation of Medicare Part C Advantage Plans or Prescription Drug Part D Plans. You should handle these reconciliation processes the same way you would resolve a group health recovery claim.

I am requesting the following services be provided:

Scope of Service	**Fee**
☐ ON BEHALF OF THE CLAIMANT(BCRC) or RESPONDENT(BCRC/CRC):	
Initiating the Medicare conditional payment notice of claim; securing preliminary conditional payment letter (CPL) and Payment Summary Form (PSF) :	$475.00
☐ Submission of Final Settlement Detail Document to CMS *without* reconciliation of PSF entries; Securing Final CMS Demand Letter:	$395.00
or	
☐ Submission of Final Settlement Detail Document to CMS *with* reconciliation of PSF entries; Securing Final CMS 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-9/10 billing codes since inception of the claim

☐ Appeals of disputed PSF entries or Demand Letters from the BCRC/CRCwill 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 will be commenced only after discussion with my office.

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

1. Specific Case Information form

2. Authorizations on behalf of the Claimant:

Proof of Representation authorization

3. Authorization on behalf of the Respondent:

Recovery Agent Authorization

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

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

_____ Date:_____

Authorized Representative Signature

Specific Case Information

Claimant/Plaintiff:

Name:
Address:
SSN/HICN:
Telephone Number:
Gender:
Date of birth:
Date of Injury: (if multiple dates of injury list earliest first)

Claimant/Plaintiff's Attorney

Name:
Address:
Telephone Number:

Employer/ Defendant (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/Plaintiff is NOT on Medicare

☐ Claimant/Plaintiff IS on Medicare

Part A:☐ Effective date of coverage:
Part B:☐ Effective date of coverage:

Body Part(s)/System(s) : (Be specific, if multiple dates of injury associate body part(s) to each date of injury).

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

Comments/Special Instructions:

PROOF OF REPRESENTATION

Type of Medicare Beneficiary Representative:

Attorney other than an Attorney of record:

Name: Angelo Paul Sevarino, Esq.
Address: 26 Barber Hill Road,
Broad Brook, CT 06016
Telephone: 860-716-0320

Medicare Beneficiary Information and Signature/Date:

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

_____
(Name as shown on Medicare card)

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

❑❑❑-❑❑-❑❑❑❑-❑❑

Date of Illness/Injury: _____

Beneficiary Signature: _____ Date signed: _____

Representative's Signature: _____ Date signed: _____
Angelo Paul Severino

To be printed on workers' compensation carrier's or third party administrator's letterhead including applicable address and telephone number.

Date:

Claim Number:
Insured Name:
Claimant Name:
Date of Injury:
Insurance Company or
Third Party Administrator Name:
Claimant's Medicare No: ❑❑❑-❑❑-❑❑❑❑-❑❑
Claimant's DOB:

Recovery Agent Authorization

This letter authorizes and appoints the below captioned entity to receive information, represent, negotiate and resolve with the Centers for Medicare & Medicaid Services (CMS), Benefits Coordination & Recovery Center (BCRC), Commercial Repayment Center (CRC) or any of its divisions or contractors regarding any and all conditional payments or rights of recovery relating to a liability insurance, no-fault insurance or workers' compensation claim as outlined above. This letter also provides authorization for the below captioned entity to act on behalf of the above referenced insurance company or third party administrator to resolve any potential recovery claim that CMS/BCRC/CRC and/or Medicare may have if there is a settlement, judgment, award or other payment made on behalf of the Claimant/Beneficiary.

This authorization is valid beginning the date first shown above in this Recovery Agent Authorization for a period of ☐ one year ☐ two years from the date first shown above.

NAME OF ENTITY:	Angelo Paul Sevarino, Esq.
ADDRESS:	26 Barber Hill Road, Broad Brook, CT 06016
TELEPHONE:	860-716-0320

_____ _____

duly authorized claim administrator

Angelo Paul Sevarino
duly appointed representative

Date:

Date:

FINAL SETTLEMENT DETAIL DOCUMENT

42 CFR 411.37(c) stipulates that Medicare will recognize a proportionate share of the necessary procurement costs incurred in obtaining a settlement. In order for Medicare to properly calculate the net Medicare conditional payment refund it is due, please supply the information outlined below. This information will also be used to update the beneficiary's records to show resolution of this matter.

Beneficiary Name:

Medicare Number: ❑❑❑-❑❑-❑❑❑❑-❑❑

Date of Incident:

Total amount of settlement: **$**_____

Amount of any medical payment or PIP benefits paid in addition to the settlement amount(liability claims only): **$**_____

Attorney fee :

$_____

Additional procurement expenses: (submit an itemized listing of these expenses) **$**_____

Date the case was settled:___/___/____

Settlement information provided by: _____

Name

_____

Address

Date submitted: ___/___/____