The signature of the authorized representative is <u>required before</u> the WCMSA analysis may be prepared or work commenced.

_____

Submitting Attorney/Party Signature **Date:_____**

Specific Case Information

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

Claimant's Attorney
Name:
Address:
Telephone Number:

Employer (if multiple employers list on separate sheet)
Name:
Address:
Telephone Number:

Insurer(if multiple insurers list on separate sheet; indicate related employer)
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) and included in the WCMSA:

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

Comments/Special Instructions:

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:_____

Request for Social Security Information

TO: Social Security Administration

_____	_____	_____
Name	Date/Birth	Social Security No.

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

Angelo Paul Sevarino. Esq., 26 Barber Hill Road, Broad Brook, CT 06016

Reason I want this information released:

To establish my Social Security Disability status, possible offset implications, date of entitlement to Medicare and the basis for Medicare entitlement (disability, age or ESRD) for the purpose of my workers' compensation or personal injury claim. I understand there may be a charge for releasing information.

Please release the following information:

(A) Social Security entitlement status; (B) date of Social Security entitlement or date of application if still pending; (C) basis for entitlement (disability, age, ESRD); (D) Medicare status; (E) date of entitlement for Medicare A, B and/or D; (F) Supplemental Security Income entitlement; (G) Medicaid entitlement; (H) If not a current Social Security recipient, include number of eligible quarters/credits; (I) Initial PIA; (J) ACE and any offset notices or calculations and (K) Family Max

I am the individual to whom the information/record applies, parent or the legal guardian of that person. I know that if I make any representation which I know is false to obtain information from Social Security, I could be punished by a fine or imprisonment or both.

Signature:_____ Date:_____ Relationship:_____
Claimant/Plaintiff

FOR SSA USE ONLY

Is the individual *currently* a Medicare and/or Medicaid (SSI**)** recipient? Yes No

If yes, Is the individual receiving:			
	Medicare Part A	Yes No	Date of Entitlement: _____
	Medicare Part B	Yes No	Date of Entitlement: _____
	Medicare Part D	Yes No	Date of Entitlement: _____
	SSI/Medicaid	Yes No	Date of Entitlement: _____

Is the individual insured for SSDIB? Yes No Number of Quarters/Credits: _____

Initial PIA_____ 80% ACE $_____ Family Max: $_____

If the individual is NOT receiving Medicare or Medicaid benefits please complete the following

Is the individual receiving *SS Retirement Benefits*? Yes No Effective Date: _____

Is the individual receiving SSDIB benefits but
is not yet a Medicare beneficiary? Yes No Date of Entitlement: _____

Has a claim or request for hearing for SSDIB/SSI
benefits been filed? Yes No Date of Request: _____

SSA Representative Signature _____ Date:_____