



THE CENTER

For Lien Resolution

Thank you so very much for your trust in choosing The Center for Lien Resolution, LLC (The Center) to assist you to resolve your Medicare and/or Medicaid liens.

Attached please find our Medicare/Medicaid Lien Intake Form. Please fill it out in its entirety. In addition to completing and signing the intake form, the first box entitled Medicare/Medicaid Lien Account provides specific information as to the documents we will need from you in order to get started.

As part of the intake form, there are several releases and authorization forms that must be signed by the claimant. Without these, the Centers for Medicare and Medicaid Services (CMS) will not communicate with us or provide us with the necessary information to assist you with resolution of these liens.

Last, per CMS regulations announced in late 2009, we need a written statement from you, indicating your approval and authorization for The Center to resolve any potential recovery claim that Medicare or Medicaid may have as a result of the liability insurance, no-fault insurance, or workers' compensation settlement, judgment, or award. **To satisfy this requirement, we will need the attached correspondence from you on your firm's letterhead.**

Thank you so much for your attention to these matters. Should you have any questions or concerns regarding any of these, please do not hesitate to contact us. Otherwise, we look forward to receiving these items from you as soon as possible and getting started right away.

On behalf of all of us associated with The Center, we truly appreciate your confidence in us and look forward to working with you on this matter.

Sincerely,

The Center for Lien Resolution

01/14/2010

Date

Re: Claimant:
Medicare#:
DOB:
DOA:

Dear MSPRC:

As attorney of record/adjuster on the above referenced matter, I authorize The Center for Lien Resolution, LLC to act on behalf of the above referenced claimant/insurer to resolve any potential recovery claim that Medicare or Medicaid may have as a result of the liability insurance, no-fault insurance, or workers' compensation claim settlement, judgment, or award.

Sincerely,

01/14/2010

KEY CONTACT AND BILLING INFORMATION

Referring Party Adjuster Name: _____ Tel. Number: _____ E-mail Address: _____
 Insurance Carrier/TPA/SA : _____ Address: _____

Referring Party Defense Attorney Name: _____ Tel. Number: _____ E-mail Address: _____
 Defense Firm Name: _____ Address: _____

Referring Party Plaintiff Attorney Name: _____ Tel. Number: _____ E-mail Address: _____
 Paralegal Name: _____ E-mail Address: _____
 Plaintiff Firm Name: _____ Address: _____

Referring Party Structured Settlement Broker: _____ Tel. Number: _____ E-mail Address: _____
 Broker Firm Name: _____ Address: _____

LITIGATION INFORMATION

If Workers' Compensation case: Has claimant made claim for or currently receiving benefits? Yes No
 Employer: _____ Carrier: _____ E/C Attorney: _____

If Liability case: Has plaintiff filed case or is litigation pending? Yes No
 Defendant: _____ Carrier: _____ D/C Attorney: _____

Settlement Information: Has case settled? Yes No
 Actual/Projected Settlement Date: _____ Gross Recovery: _____

Attorney Fees and Costs: _____ Net Proceeds to Claimant: _____

Is claimant covered by other Insurance:
 Private Yes No Military Insurance Yes No VA Coverage Yes No

If yes who? _____

PUBLIC BENEFIT INFORMATION

Has the claimant ever received Medicare benefits? Yes No

If yes, entitlement date: _____ Monthly Premium: _____

Medicare Coverage: Part A Part B Part C Part D

Is the claimant currently receiving SSR/SSD? Yes No

If yes, entitlement date: _____ Monthly Amount: _____

Is the claimant currently receiving Medicaid benefits? Yes No

If yes, entitlement date: _____ Carrier Name: _____

Is the claimant currently receiving SSI? Yes No

If yes, entitlement date: _____ Monthly Amount: _____

ATTESTATION

The above information is provided to The Center for Lien Resolution (The Center) for purposes of creating a Medicare/Medicaid Lien Account. I affirm and hereby attest under oath that all of the information provided herein is accurate and truthful. Should The Center rely on information provided by me, which turns out to be untruthful or inaccurate, I hold The Center harmless and shall indemnify it for any and all actions, debts, contracts, or other legal responsibilities they incur as a result of such untruthful or inaccurate information and further agree to assume and become responsible for all such actions, debts, contracts, or other legal responsibilities.

Signature: _____ Date: _____

The Center for Lien Resolution

4912 Creekside Drive
Clearwater, FL 33760
(800) 498-8382
Fax: (727) 471-1853
www.lienresolutionservices.com



THE CENTER
For Lien Resolution

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
4912 Creekside Dr.
Clearwater, FL 33760
1-800-498-8382

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's/Legal Representative Signature

Date Signed

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.

01/14/2010

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

The Center for Lien Resolution
4912 Creekside Dr.
Clearwater, FL 33760
1-800-498-8382

This request and authorization is for the purpose of and applies to: Medicare/Medicaid lien account.

Healthcare information relating to the following treatment, condition, or dates: _____

All healthcare information.

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

No

Yes I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

No

I understand that the information that I have specifically authorized the release of, may be redisclosed by The Center for Lien Resolution Services and that my information would no longer be protected by the federal privacy regulations. Therefore, I expressly release the health care provider named in paragraph two above, their employees, contractors, and records custodians from any liability arising from the disclosure and release of my health information pursuant to this agreement. I understand that I may revoke this authorization by written notice to the health care provider named in paragraph two above, knowing however that previously disclosed information would not be subject to my revocation request.

I agree that a Photostat copy of this authorization shall be considered as effective and valid as the original.

If signed by the Legal Representative, a copy of the document(s) authorizing said representative to act on behalf of the claimant must be attached to this consent. Examples of such documents include a Durable Power of Authority, Letters of Guardianship/Conservatorship, or other legal document that establishes such authority.

Patient/Legal Representative Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES TWO YEARS FROM DATE OF SIGNATURE