MSA Services, LLC
The Leader In MSP Compliance

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PROOF OF REPRESENTATION

The language below authorizes Gregory Lisowski of MSA Services, LLC, a Medicare set aside vendor, to receive information, including identifiable health information, from the centers of Medicare and Medicaid Services (CMS), Coordination of Benefits and Recovery (COB&R), BCRC and/or CRC relating to my liability insurance (including self-insurance), no-fault insurance or workers' compensation claim. This also provides authorization to Gregory Lisowski of MSA Services, LLC to act on my behalf to resolve any potential recovery claim that Medicare may have if there is a settlement, judgment, award or other payment made on behalf of my insurance claims.

I, _____(print name exactly as shown on your Medicare card) hereby authorize the 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 REPRESENT YOU WITH REGARD TO THE ABOVE:
(If you intend to have your information released to more than one individual or entity, you must complete a separate release for each one.)

☐ Insurance Company

☐ Workers' Compensation Carrier

☐ Other: Third party vendor: Gregory Lisowski of MSA Services, LLC
95 Glastonbury Boulevard - Suite 216
Glastonbury, CT 06033-4453
(866) 306-9423 Phone

CHECK ONLY ONE OF THE FOLLOWING TO INDICATE HOW LONG CMS/MSPRC/MEDICARE MAY RELEASE YOUR INFORMATION:

☐ One Year ☐ Two Years ☐ Until the lien/conditional payments are resolved

MEDICARE BENEFICIARY INFORMATION AND SIGNATURE

Medicare Number on card (HICN):_____ Date of Injury/Illness:_____

Beneficiary signature: _____ Date signed:_____

Gregory Lisowski signature:_____ Date signed:_____