PROOF OF REPRESENTATION REGARDING MEDICARE CONDITIONAL PAYMENTS

This document authorizes Gregory Lisowski, to receive information, including identifiable health information, from the centers of Medicare and Medicaid Services (CMS), Coordination of Benefits and Recovery (COB&R), BCRC, CRC and any Medicare Advantage Plan relating to my liability insurance (including self-insurance), no-fault insurance or workers' compensation claim. This also provides authorization to Gregory Lisowski 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:

Gregory Lisowski (Individual other than my attorney)
47 Waterbury Road – Suite 357
Prospect, CT 06712
Phone/Fax (866) 306-9423
glisowski@msaservicesllc.com

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

This authorization is good from: _____
Fill in Start Date

☐ One Year ☐ Two Years **X** 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: Gregory Lisowski Date signed:_____