PROOF OF REPRESENTATION

The undersigned Medicare beneficiary informs the Centers for Medicare & Medicaid Services (CMS) that they have given the specified legal representative the authority to represent them and act on their behalf with respect to any claims for liability insurance, no-fault insurance, or workers compensation, including releasing identifiable health information or resolving any potential recovery claim that Medicare may have if there is a settlement, judgment, award, or other payment. The undersigned representative agrees that they represent the stated Medicare beneficiary.

Type of Representative:	**Authorized Representative:**
( ) Individual other than an Attorney: (X) Attorney ( ) Guardian* ( ) Conservator* ( ) Power of Attorney*	_____ (Attorney/ Law Firm Name) _____ (Law Firm Address) _____ (Law Firm City, State, Zip) _____ (Phone Number)

* If the beneficiary is incapacitated, his/her guardian, conservator, power of attorney etc. will need to submit documentation in addition to this proof of representation.

Medicare Beneficiary Information:

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

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

Date of Illness/Injury **for which the beneficiary has filed a liability insurance, no-fault insurance or workers' compensation claim:** _____

Beneficiary's Signature: _____ Date signed: _____

Representative's Signature: _____ Date signed: _____
(Attorney)