James E. Logan & Associates, Ltd.
Settlement Consultants

Medicare Conditional Payment Assignment

(FOR WORKERS' COMPENSATION CLAIMS)

TO: *James E. Logan & Associates, Ltd.*
32255 Northwestern Highway, Suite 215
Farmington Hills, MI 48334
tparker@jeloganltd.com

FROM: _____

ASSIGNMENT: Based on the following information, please determine whether any conditional payments have been made, including the amounts, payees, dates of service and the diagnosis and treatment codes. Attached is a completed and signed **CONSENT TO RELEASE** form for your use.

COST: $150.00 per inquiry or follow-up inquiry

EMPLOYEE / CLAIMANT

Name: _____ Sex: M ☐ F ☐

Date of Birth: _____ SSN: _____

Telephone: _____ HICN: _____
(Medicare Number)

Address: _____

City/State/Zip: _____

Date of Accident: _____

Description of Injury: _____

Claim No.: _____

ATTORNEY

Name _____

Firm Name _____

Address: _____

City/State/Zip _____

Email: _____ Tele.: _____ Fax: _____

EMPLOYER

Name: _____

Address: _____

City/State/Zip: _____

Contact Name: _____

Email: _____ Tele: _____ Fax: _____

INSURER

Insurer / TPA: _____

Address: _____

City/State/Zip: _____

Contact Name: _____

Email: _____ Tele: _____ Fax: _____

ATTORNEY

Name: _____

Firm Name: _____

Address: _____

City/State/Zip: _____

Email: _____ Tele.: _____ Fax: _____

ADDITIONAL COMMENTS / INSTRUCTIONS:

Consent to Release

I hereby authorize the Centers for Medicare & Medicaid Services (CMS), its agents and/or contractors to release, upon request, information concerning Medicare Conditional Payments made relating to my injury/illness and/or settlement for the specified date of injury/illness to the individual and/or entity listed below:

Name of Entity:	***James E. Logan & Associates, Ltd.***
Contact for above entity:	Tina Parker or other authorized representative
Address:	32255 Northwestern Highway, Suite 215 Farmington Hills, MI 48334
Telephone:	(248) 865-3900

This Consent remains valid for a period of:

( ) One Year ( ) Two Years ( ) Other _____
(Provide a specific period of time)

I understand that I may revoke this "Consent to Release" at any time.
(Please contact James E. Logan & Associates, Ltd. to obtain contact information for revocations.)

MEDICARE BENEFICIARY INFORMATION AND SIGNATURE:

Beneficiary Signature: _____ Date Signed: _____

Beneficiary Name: _____
(Please print exactly as shown on your Medicare card)

Medicare Number: _____
(The number on your Medicare card)

Social Security Number: _____

Date of Accident: _____