James E. Logan & Associates, Ltd.

Settlement Consultants

Medicare Conditional Payment Assignment

(FOR LIABILITY 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

CLAIMANT/PLAINTIFF

Name: ______________________________ Sex: M ☐ F ☐

Date of Birth: ____________________ SSN: ____________________

Telephone: ____________________ HICN: ____________________
(Medicare Number)

Address: ______________________________

City/State/Zip: ______________________________

Date of Accident: ____________________

Description of Injury: ______________________________

Claim No.: ______________________________

CLAIMANT/PLAINTIFF ATTORNEY

Name ______________________________

Firm Name ______________________________

Address: ______________________________

City/State/Zip ______________________________

Email: ____________________ Tele.: ____________________ Fax: ____________________

INSURED/SELF-INSURED

Name: ______________________

Address: ______________________

City/State/Zip: ______________________

Contact Name: ______________________

Email: ______________ Tele: ______________ Fax: ______________

INSURER

Insurer / TPA: ______________________

Address: ______________________

City/State/Zip: ______________________

Contact Name: ______________________

Email: ______________ Tele: ______________ Fax: ______________

INSURED/INSURER ATTORNEY

Name: ______________________

Firm Name: ______________________

Address: ______________________

City/State/Zip: ______________________

Email:______________ Tele.: ______________ Fax: ______________

ADDITIONAL COMMENTS / INSTRUCTIONS:

James E. Logan & Associates, Ltd.

Settlement Consultants

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: ______________________________