James E. Logan & Associates
SETTLEMENT CONSULTANTS

PROOF OF REPRESENTATION

The undersigned Medicare beneficiary hereby notifies the Centers for Medicare & Medicaid Services (CMS) that he/she has given the representative specified below 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. CMS, its agents and/or contractors are hereby authorized 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:

TYPE OF MEDICARE BENEFICIARY REPRESENTATIVE

(X) Individual other than an Attorney

Name: Any agent or representative of the Firm or Company named below.

Relationship to the Claimant/Medicare Beneficiary: Settlement Consultant

Firm or Company Name: ***James E. Logan & Associates***
Address: 28175 Haggerty Road
Novi, MI 48377
Telephone: (248) 865-3900

CLAIMANT / MEDICARE BENEFICIARY INFORMATION AND SIGNATURE / DATE:

Claimant / Beneficiary Name: _____
(Exactly as shown on your Medicare card)

Medicare Number: _____
(The number on your Medicare card.
Please attach Medicare card, if available.)

Social Security Number: _____

Date of Injury/Illness: _____

Beneficiary Signature: _____ Date Signed: _____

REPRESENTATIVE SIGNATURE /DATE

Representative Signature: _____ Date Signed: _____
Debra J. Iacovacci