MSA ADVOCATES, INC.

505 East Fayette Street, Suite 214, Syracuse, New York 13202
Phone: (315) 472-7965 Fax: (315) 472-2616

BENEFICIARY (CLAIMANT/PLAINTIFF) CONSENT TO RELEASE FOR OBTAINING LIEN/CONDTIONAL PAYMENTS WITH BENEFITS COORDINATION AND RECOVERY CONTRACTOR (BCRC)/ and/or COMMERICAL REPAYMENT CENTER (CRC) - CMS/MEDICARE

The language below authorizes **MSA Advocates, Inc**., a Medicare Set Aside Vendor, to receive information, including identifiable health information, from the Centers of Medicare & Medicaid Services (CMS) relating to my liability insurance (including self-insurance), no-fault insurance or workers' compensation claim. This authorization also provides authorization to **MSA Advocates, Inc.** 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 your 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:

CHECK ONLY ONE OF THE FOLLOWING TO INDICATE WHO MAY RECEIVE INFORMATION AND REPRESENT YOU WITH REGARD TO THE ABOVE:
(If you intend to have your information released to more than one individual or entity, you must complete a separate release for each one.)
( ) Insurance Company ( ) Workers' Compensation Carrier **(X) Other: MSA Advocates, Inc.**

Name of entity**:** **MSA Advocates, Inc., a National Medicare Set Aside Vendor**
Contact for above entity: **Office Manager**
Address: **505 E. Fayette Street, Suite 214, Syracuse, New York 13202**
Telephone: **315-472-7965**

CHECK ONE OF THE FOLLOWING TO INDICATE HOW LONG CMS/MEDICARE MAY RELEASE YOUR INFORMATION (The period you check will run from when you sign and date below.)**:**
( ) One Year ( ) Two Years or (X) Other: Until such time as the lien/conditional payment(s) is/are resolved with the BCRC and/or CRC on my behalf or three years from the date signed, which ever date is sooner.
I understand that I may revoke this "consent to release information" at any time, in writing.

MEDICARE BENEFICIARY INFORMATION AND SIGNATURE:

Beneficiary Signature: _____ Date signed: _____

Note: If the beneficiary is incapacitated, the submitter of this document will need to include documentation establishing the authority (power of attorney) for the individual signing on the beneficiary's behalf.

Medicare Health Insurance claim Number (The number on your Medicare card.): _____

Date of Injury or illness: _____
Authorized Representative for MSA Advocates' Signature/Date:_____
Dated: _____