MSPRC - Natalie Bonfigilio

CONSENT TO RELEASE

The language below should be used when you, a Medicare beneficiary, want to authorize someone other than your attorney or other representative to receive information, including identifiable health information, from the Centers for Medicare & Medicaid Services (CMS) related to your liability insurance (including self-insurance), no-fault insurance or workers' compensation claim. 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 THEN PRINT THE REQUESTED INFORMATION:
☐ Insurance Company☐ Workers' Compensation Carrier☐ Other (Attorney)

Name of Entity: Rosenbaum & Associates

Contact for above Entity:

Address: 1818 Market Street

Address Line 2: Suite 3200

City, State, and Zipcode: Philadelphia, PA 19103

Telephone: (215) 569-0200

CHECK ONE OF THE FOLLOWING TO INDICATE HOW LONG CMS MAY RELEASE YOUR INFORMATION:

(The period you check will run from when you sign and date below)

☐ One Year☐ Two Years☐ Other

If choosing other, please provide specific period of time: _____

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: April 25, 2024

Note: If the beneficiary is incapacitated, the submitter of this document will need to include documentation establishing the authority of the individual signing on the beneficiary's behalf. Please visit https://go.cms.gov/cobro for further instructions.

Medicare ID (The number on your Medicare card): _____
Date of Injury/Illness: _____

PROOF OF REPRESENTATION

The language below should be used when you, the Medicare beneficiary, want to inform the Centers for

Medicare & Medicaid Services (CMS) that you have given another individual the authority to represent you and act on your behalf with respect to your claim 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. You are not required to use this model language, but proof of representation must include the information provided in this model language. Your representative must also sign that he/she has agreed to represent you. This model language also makes provisions for the information your representative must provide.

Note: If you have an attorney, your attorney may be able to use his/her retainer agreement instead of this language. (If the beneficiary is incapacitated, his/her guardian, conservator, power of attorney etc. will need to submit documentation other than this model language.) Please visit https://go.cms.gov/cobro for further instructions.

Type of Medicare Beneficiary Representative:

(Check one below and then print the requested information)

- ☐ Individual other than an Attorney
- ☐ Attorney
- ☐ Guardian
- ☐ Conservator
- ☐ Power of Attorney

Name: Jeffrey M. Rosenbaum, Esquire

Relationship to the Beneficiary: Attorney

Firm or Company Name: Rosenbaum & Associates

Address: 1818 Market Street

Address Line 2: Suite 3200

City/State/Zipcode: Philadelphia, PA 19103

Telephone: (215) 569-0200

Medicare Beneficiary Information and Signature/Date:

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

Beneficiary's Medicare ID: _____
(number on your Medicare card)

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

X _____

Signature Certificate

Document name: MSPRC - Natalie Bonfigilio

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