



Medicare Conditional Payment Assignment

(FOR WORKERS' COMPENSATION CLAIMS)

TO: *James E. Logan & Associates, Ltd.*
31800 Northwestern Highway, Suite 130
Farmington Hills, MI 48334
tcorcoran@jeloganltd.com

FROM: _____

ASSIGNMENT: Based on the following information, please determine if the Employee/Claimant is a Medicare beneficiary and 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 **AUTHORIZATION TO RELEASE INFORMATION** 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 Injury: _____
Description of Injury: _____

ATTORNEY

Name _____
Firm Name _____
Address: _____
City/State/Zip _____
Email: _____ Tele.: _____ Fax: _____

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EMPLOYER

Name: _____

Address: _____

City/State/Zip: _____

INSURER

Insurer / TPA: _____

Address: _____

City/State/Zip: _____

Claim No.: _____

Contact Name: _____

Email: _____ Tele: _____ Fax: _____

ATTORNEY

Name: _____

Firm Name: _____

Address: _____

City/State/Zip: _____

Email: _____ Tele: _____ Fax: _____

ADDITIONAL COMMENTS / INSTRUCTIONS:

Large empty rectangular box for additional comments or instructions.



Authorization to Release Information

NAME: _____

SOCIAL SECURITY NUMBER: _____

MEDICARE NUMBER (HICN): _____

DATE OF BIRTH: _____

DATE OF INJURY: _____

In compliance with the Federal Privacy Act of 1974 and the HIPAA Privacy Rule, the undersigned authorizes the Centers for Medicare & Medicaid Services (CMS), and their contractors, to release to James E. Logan & Associates, Ltd., or their representative, any and all information concerning conditional payments made by Medicare resulting from the personal injury, which occurred on the date listed above.

The undersigned also hereby authorizes James E. Logan & Associates, Ltd. to disclose his/her Social Security number to CMS and their contractors.

The undersigned also hereby authorizes James E. Logan & Associates, Ltd. to disclose his/her Social Security number to the Social Security Administration to determine social security benefits (for the purposes of determining Medicare eligibility).

This form expires in one year from the date of execution; however, the undersigned may revoke this authorization form by sending a request in writing at any time to the appropriate office below:

MSPRC
Workers' Compensation
Post Office Box 33831
Detroit, MI 48232
Tel (866) 677-7220
Fax (734) 957-0998

MSPRC
Liability
Post Office Box 33828
Detroit, MI 48232
Tel (866) 677-7220
Fax (734) 957-0998

SIGNED: _____

DATE: _____