Proof of Representation

I, _____, hereby inform the Centers for Medicare & Medicaid Services (CMS) that I grant the individual(s) listed below the authority to me and act on my behalf with respect to my claim, including releasing identifiable health information or resolving any potential recovery claim that Medicare may have if there is a settlement, judgement, award, or other payment.

Type of Medicare Beneficiary Representative

(X) Individual other than an Attorney

Manley & Associates
P.O. Box 450534
Atlanta, GA 31145-0534

As the designated Representative for (Claimant Full Name) _____ , Manley & Associates has the authority to communicate with CMS and MSPRC in regards to obtaining conditional payment information and/or a recovery demand letter, as well as disputing/negotiating any request/demand for Conditional Payment Reimbursement on the following Medicare Beneficiary:

Medicare Beneficiary Information and Signature/Date:

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

Beneficiary's Health Insurance Claim Number (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: _____

Beneficiary Signature: _____ Date signed: _____

Representative Signature/Date:

Representative's Signature: _____ Date signed: _____