



# PROOF OF REPRESENTATION

\_\_\_\_\_  
Beneficiary Name (PRINT as shown here)

\_\_\_\_\_  
Medicare Number (as shown here)

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of Accident



I \_\_\_\_\_ hereby authorize the Centers for Medicare and Medicaid Services (CMS), its agents and/or contractors to release any and all information regarding status of conditional payments related to the injury/illness and/or settlement that have/have not been made on the above specified claim.

I am entrusting the below entity to submit and receive information on my behalf in order to resolve Medicare’s right to recovery: (X) TPA

**Lien Settlement Solutions, LLC.** Phone: (877)907-5436  
**1500 E. Robinson Street** Fax: (877)408-8194  
**Orlando, FL 32801**

CMS may release information to the above noted entity ongoing until this matter is resolved, beginning on \_\_\_\_/\_\_\_\_/\_\_\_\_

**I understand that I may revoke this “Proof of Representation” at any time in writing.**

\_\_\_\_\_  
**Beneficiary Signature/** Relationship of Rep. \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Personal Representative** Date Signed

(Please provide any supportive documentation confirming the personal representative (e.g. Court Order approving Estate Representative, Durable Power of Attorney, etc.))

\_\_\_\_\_  
**Attorney Signature** Date Signed

\*\*\*\*\***FOR LSS USE ONLY**\*\*\*\*\*  
Lien Settlement Solutions accepts this beneficiaries request for our representation in the handling of the conditional payments that may/may not have been made in this matter.  
\_\_\_\_\_  
**LSS, Representative Signature** Date Signed