



THE LIEN RESOLUTION GROUP

PROTECTING PROCEEDS AND GOVERNMENT BENEFITS

Thank you for contacting us to discuss your Medicare/Medicaid Claim needs. We will act on your claimant's behalf to determine if there are any claims from Medicare/Medicaid and if so compromise, settle or execute releases of these claims.

In order for us to determine the services necessary for each individual case we will need the following information submitted:

- Completed case intake (attached)
- Signed Releases (CMS/SSA) (attached)
- Copy of the Summons & Complaint
- Copy of the Bill of Particulars
- Copy of any correspondence with Medicare/Medicaid

If your claimant's case has settled we will need a copy of the Settlement Statement itemizing the breakdown of the settlement and a copy of the signed Settlement Agreement & Release.

The total costs involved for us to address Medicare/Medicaid's claims will be \$1,800.00.

If you have any questions regarding Medicare/Medicaid claims please contact Brett Newman at 1-800-888-1743.

Please submit all of the requested information above to:

The Lien Resolution Group
275 Route 304, Suite 300
Bardonia, New York 10954

Or emailed to:

bnewman@helpwithliens.com
jfrankl@helpwithliens.com
ldunnfox@helpwithliens.com

275 Route 304, Suite 300
Bardonia, New York 10954
Phone: 800.888.1743



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Phone: 800-888-1743

Fax: 845-638-1237

275 ROUTE 304, SUITE 300, BARDONIA, NEW YORK 10954

Date

CLAIMANT INFORMATION

Name

Address:

City/State/Zip

Phone:

Male Female

Date of Birth:

Social Security #

Other contact person:

INJURY INFORMATION

Type of case

Med Mal MVA PI WC WD other

Date of Injury

Date of last treatment

Date of Death

Has Client has surgery as a result of injury? Yes No

(Please include Letters of Administration if claimant is deceased)

If Yes: Surgery Type

Description of Injury:

Pre Existing Conditions:

BENEFIT INFORMATION:

Medicare Benefits:

Yes No

Medicare HIC Number

Entitlement Date

Medicare Coverage

Part A Part B Both

Was case reported to Medicare

Yes No

MEDICAID BENEFITS

Yes No

Medicaid Number

SSI - Supplemental Security Income

Yes No

CARRIER INFORMATION/ LIABILITY INSURER

Carrier Name

Claim number

CLAIMANT ATTORNEY

Name:

Firm

Address

City/State/Zip

Phone:

Fax

Attorney Email

Paralegal

Email

WORKERS COMP (applied or receiving)

Yes No

OTHER (Private Health Insurance)

Yes No

SETTLEMENT INFORMATION

Case Settled

Yes No

Date of Settlement

Gross Recovery

Attorney Fees

Net to Client

Case Expenses

Additional Information:

CONSENT TO RELEASE

I, hereby authorize

its agents and/or contractors to release, upon request, information related to my injury/illness and/or settlement to the individual(s) and/or firm(s) listed below:

PLEASE CHECK:

Claimant's attorney
(Name and/or Firm)

(Address)

Insurance Carrier
(Name and/or Company)

(Address)

Other
(Name and/or Firm)

(Address)

How long can we give out information? (CHECK ONE BOX)

Ongoing, beginning
(Month/Date/Year)

Limited time through
(Month/Date/Year) (Month/Date/Year)

Claimant's Signature

Date Signed

Date of Injury

Medicare Number

If your Power of Attorney (POA) or legal representative signed this form for you, a copy of their POA or representation papers must be sent to us with this form.

Completion and signing of this consent form:

- * Authorizes release of information to the person named above upon their request. This means that information disclosed to the above named person may be re-disclosed by them and may no longer be protected by law.
- * Allows release of claims and other information related to your injury/illness.
- * Is for release of information purposes only and does not affect benefits you are entitled to under the Medicare/Medicaid Program.

A photocopy or facsimile of this Consent to Release Form shall be valid and given the same force and effect as the original.

