HCS HUMMEL CONSULTATION SERVICES Conditional Payment Search Request

1. Complete All Fields:

All fields in this section must be completed.

Claimant's Full Name		Print exaclty as shown on their Medicare card.
Claimant's Address: Street, City, State, Zip		
Claimant's Date of Birth		
Date of Injury / Illness / Onset		A specific date must be provided. If date is month/year only use '1' as the day. If date is year only use January 1.
Medicare Number		Also known as the Medicare Beneficiary Identifier (MBI) number.
Injured Body Parts and Brief Description of Injury		All injuries alleged, accepted, or released by settlement.

Has the claimant ever participated in a Medicare Part C or Part D plan? Yes ☐ No ☐ If yes, a separate lien search may be necessary. Please contact Hummel Consultation Services for further information.

2. Is the Claimant Represented?

Yes ☐ No ☐ If Yes, complete all fields:

Claimant's Attorney Name		
Firm		Abbreviated names are okay.
Firm Address: Street, City, State, Zip		

3. Is this a Workers' Compensation Claim?

Yes ☐ No ☐ If Yes, complete all fields:

Claimant's Employer		
Employer's Address: Street, City, State, Zip		
Work Comp Claim Number		If multiple numbers, use the primary claim number.
Work Comp Insurance Carrier		If multiple carriers, use the primary work comp carrier.
Primary Contact / Case Adjuster		
Work Comp Carrier Address: Street, City, State, Zip		

4. Is this a Liability Claim?

(If you have a no-fault claim or a no-fault component, please contact HCS.) Yes ☐ No ☐ If Yes, complete all fields:

Defendant's Name		If multiple defendants, use the primary defendant as named in the case.
Defendant's Address: Street, City, State, Zip		
Defendant's Insurance Claim Number		If multiple numbers, use the primary claim number.
Defendant's Insurance Carrier		If multiple insurers, use the primary insurer for the defense.
Defendant's Insurance Carrier's Address: Street, City, State, Zip		If this is neither a Work Comp nor a Third Party Liability claim, please call our office.

5. Request the Claimant complete and return the Proof of Representation Letter.

The Proof of Representation Letter must be completed, signed and dated by the claimant. Ensure that the claimant's name and HICN are exactly as shown on their Medicare card.

Extra Letters may be found at our website:

http://www.hummelcs.com/downloads/HCSProofofRepresentation.pdf

6. Request the Claimant complete and return the Consent to Release Form.

The claimant must sign and date the Consent to Release Form. Longer time periods granted help to ensure the most efficient lien search process.

Extra Releases may be found at our website:

http://www.hummelcs.com/downloads/HCSMedicareRelease.pdf

7. Forward to Hummel Consultation Services the following:

1. This completed Conditional Payment Search Request Form.
2. The completed, signed and dated Proof of Representation Letter. (step 5.)
3. The completed, signed and dated Consent to Release Form. (step 6.)

Not all items need to be forwarded simultaneously. Hummel Consultation Services will hold the conditional payment search request until all items are received.

Your Name:		E-Mail:	
Telephone:		Fax:	

Send All Materials To: Mail: HCS, PO Box 148, Ferdinand, IN 47532-0148
Fax: 978-338-8116
Email: joseph@hummelcs.com

HUMMEL CONSULTATION SERVICES

POST OFFICE BOX 148
FERDINAND, INDIANA 47532-0148

CHRISTINE L. HUMMEL, ESQ.
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christine@hummelcs.com

JOSEPH A. HUMMEL, IV
Vice President of Operations
joseph@hummelcs.com

Telephone: (603) 758-1410
Facsimile: (978) 338-8116

http://www.hummelcs.com

CONSENT TO RELEASE

I, _____ (print your name exactly as shown on your Medicare card) hereby authorize someone other than my attorney or other representative to receive information, including identifiable health information, from the Centers for Medicare & Medicaid Services (CMS) related to my 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:

(If you intend to have your information released to more than one individual or entity, you must complete a separate release for each one.)

( ) Insurance Company ( ) Workers' Compensation Carrier (X) Other: Third Party Administrator

Name of entity: Hummel Consultation Services

Contact for above entity:

Address: Post Office Box 148
Ferdinand, Indiana 47532-0148

Telephone: (603) 758-1410

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 _____
(Provide a specific period of time)

MEDICARE BENEFICIARY INFORMATION AND SIGNATURE:

Beneficiary Signature: _____ Date Signed: _____

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.

Medicare Health Insurance Claim Number or Medicare Beneficiary Identifier: _____

Date of Injury/Illness: _____

HUMMEL CONSULTATION SERVICES

POST OFFICE BOX 148
FERDINAND, INDIANA 47532-0148

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PROOF OF REPRESENTATION

I, the Medicare Beneficiary as named below, hereby give another individual the authority to represent me and act on my behalf with respect to my 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.

Type of Medicare Beneficiary Representative:

(X) Individual other than an Attorney:

( ) Attorney*

( ) Guardian*

( ) Conservator*

( ) Power of Attorney*

Name:

Relationship to the Beneficiary: Third Party Administrator

Firm or Company Name: Hummel Consultation Services

Address: Post Office Box 148
Ferdinand, Indiana 47532-0148

Telephone: (603) 758-1410

* Note: If I have an attorney, my 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 additional documentation other than this Proof of Representation. I grant authority to any current employee or owner of the Firm named above, regardless of the listed Individual.

Medicare Beneficiary Information and Signature/Date:

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

Beneficiary's Health Insurance Claim No. or Medicare Beneficiary Identifier: _____

Date of Illness/Injury for which the Beneficiary has filed a liability insurance, no-fault insurance or workers' compensation claim: _____

Beneficiary Signature: _____ Date Signed: _____

By signing, I the Beneficiary affirm and agree that no relationship, attorney-client, contractual or otherwise is hereby formed with Hummel Consultation Services (HCS), and that HCS was retained by another party acting on my behalf. I affirm and agree that HCS is not in any way legally or otherwise responsible for compliance with any current or future provisions, or current or future promulgated rules and regulations, of the Medicare Secondary Payer Act. I affirm and agree that HCS is not legally or otherwise responsible for reimbursement of the CMS/MSPRC Conditional Payment Lien that is now or may ever be present, on this or any claim that I may have, and that HCS cannot in any way be held responsible for failure to pay any Conditional Payment Lien that is now or may ever be present.

Representative Signature/Date:

Representative's Signature: _____ Date Signed: _____