HUMMEL CONSULTATION SERVICES

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

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

POST OFFICE BOX 148
FERDINAND INDIANA 47532-0148

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

http://www.hummelcs.com

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 Number 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: _____