THE CENTER
For Medicare Set-Aside Administration

MSA Administration Case Information

Name:____
Last First M.I. Gender

Address:____
Street Address City State Zip Code

Phone: ____________________ Date of Birth:_______________ Social Security Number:____________________

Medicare: ☐Yes ☐No If yes, Medicare Number:______________________
If no, eligible within 30 months of the settlement: ☐Yes ☐No

Accident/Injury Information

Type of Case: ☐Workers Comp. ☐Liability Description of Accident:__________________________________

Case Jurisdiction (State):_________ Date of Accident:___________________________

Description of Injury:____

Pre-existing Conditions:____

Date of Settlement:_________________ Gross Settlement Amount: $__________________

MSA Approved by CMS: ☐Yes ☐No ☐Expected

Medicare Set-Aside Account Funding

Amount Administered: $_____________________

Public Benefit Information

Is the claimant expected to receive, or currently receiving any of the following benefits?

Social Security Retirement (SSR) or Disability (SSDI) ☐Yes ☐No ☐Expected
Supplemental Security Income (SSI) ☐Yes ☐No ☐Expected
Medicaid ☐Yes ☐No ☐Expected

Referring Party or Law Firm

Name:__________________________________ Phone:_______________ Email:____________________________

Firm Name:____

Address:____

Firm Contact:______________________________________ Email:____

Residual Beneficiary Information (Please use additional sheets if needed)

Name:____
Last First M.I. Gender
Address:____
Street Address City State Zip Code
Relationship: _______________ Social Security Number:________________ Date of Birth:_____________________
(If a minor)

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Warranty

The above information is being provided to The Center for Medicare Set-Aside Administration, LLC (The Center) for the purpose of creating a Medicare Set-Aside Account which will be professionally administered by The Center. I hereby affirm and warrant by my signature that all of the information herein is accurate and complete to the best of my understanding. I further affirm and agree that I shall hold The Center harmless and indemnify it from any detrimental result that may occur from its reliance on any information provided by me that may later prove to be inaccurate or incorrect.

Signature:____ Date:____

Prior to administering please provide us with a copy of the allocation and CMS approval letter, if applicable. Please provide us with a list of treating physicians (name and address) as well as medications related to the injury.

Fee Schedule

$2,000 One-time account set-up fee

$1,000 Yearly administration fee

Internal Use Only:

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CMS Consent to Release Form

I, ____, authorize The Center for Medicare and Medicaid Services (CMS), its agents and/or contractors to release any and all records to the person or entity below.

The Center for Medicare Set-Aside Administration, LLC
4912 Creekside Drive
Clearwater, FL 33760
727-471-1850

By completing and signing this consent form, I recognize and acknowledge that this consent: a) is for release of information purposes only and will have no affect on any benefits to which I may be entitled under the Medicare and/or Medicaid Program; b) allows the release of Medicare and Medicaid claims and other information related to my injury and/or illness; and, c) authorizes the release of information to the person(s) named above upon their request and that any such released information may be re-disclosed by them and may no longer be protected by law.

I further understand that I have the right to revoke my consent and authorization at any time in writing, except to the extent that CMS has already taken action in reliance thereof. If not previously revoked by me, this consent will terminate automatically when all claims, if any, have been resolved and all Medicare Secondary Payer files have been closed.

____ ________________________________
Claimant/Legal Representative Signature Date

____ ________________________________
Date of Injury/Accident Medicare Number

If signed by your legal representative, a copy of the documents authorizing your representative to act for you must be attached to this consent. Examples of such documents would include a Durable Power of Attorney, Letters of Guardianship/Conservatorship, or any other document that establishes your representative's authority.

PRIVACY STATEMENT

The information to be collected in regard to this consent will be used in furtherance of, and to comply with, Section 1862(b) of the Social Security Act (42 U.S.C. 1395y). This information will be used to determine whether any medical services received are covered by Medicare or Medicaid, or whether a no-fault, automobile, liability insurer, or any other person(s) may be responsible for such payment.

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

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HIPAA COMPLIANT AUTHORIZATION

Authorization for the Use and Disclosure of Protected Health Information

1. Personal Information:

   Name: ______________________________________ Birth Date: ____________________________

   ID Number: _________________________________ OR Social Security Number:_______________

2. I give permission to____(hereafter "Entity") and its contract representatives to share the health information listed below with the following:

   The Center for Medicare Set-Aside Administration, LLC
   4912 Creekside Drive
   Clearwater, FL 33760
   727-497-4330

3. Indicate the purpose for which the disclosure is to be made:

   __X__To substantiate claim relating to a lawsuit or claim
   __X__Other

4. Indicate the information that you want to be disclosed, related to the following:

   __X__ Any and All records requested.

5. Enter the specific date that you want this authorization to expire: (i.e., one year from date of release)____________________________ (If you do not enter a date, this authorization will expire in five years.)

   I understand that the information described above may be redisclosed by the person or group that I hereby give Entity, its employees, and its agents permission to share my information with, and that my information would no longer be protected by the federal privacy regulations. Therefore, I release Entity, its employees, and its agents from all liability arising from the disclosure of my health information pursuant to this authorization. I understand that I may inspect or request copies of any information disclosed by this authorization if Entity, its employees, or its agents required the submission of this HIPAA Authorization in order to release information. I understand that I may revoke this authorization by notifying Entity through its employees and/or agents, in writing, knowing that previously disclosed information would not be subject to my revocation request. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or eligibility for benefits.

6. Print Name____Date__________________________

   Signature____

   Or (please provide a copy of your letters of guardianship or conservatorship, durable power of attorney, etc., if applicable)

   Name of Legal Representative (Print)____

   Relationship____

   Signature of Legal Representative___________________________________Date________________