

PROSPECTIVE NEW CLIENT GUIDE

Thank you for your interest in our services. To help us get you the information you need regarding any Medicare conditional payments in your matter, please note the following.

1. New File Referral form and prepaid fee: Before we can begin work on your matter we need the enclosed New File Referral Form completed and returned to us and the total flat fee of \$500 paid. The fee can be paid by check, money order or credit card (Visa or MasterCard). Checks or money orders should be made payable to Gullen & Associates pllc. To pay by *Visa* or *MasterCard*, please complete and return the following:

Name on credit card: _____ Type: __Visa __MasterCard

Card number: _____ Expires: _____ / _____

Address associated with credit card: _____

Signature: _____ Amount of charge: \$500.00

2. Consent to Release and Proof of Representation forms: Before we can obtain any conditional payment information from the Centers for Medicare and Medicaid Services (CMS) we need to provide CMS with a signed Consent to Release form and a signed Proof of Representation form, blank copies of which are attached. Please have the claimant sign the forms and return to us at the address or fax or email address shown at the bottom of this page.

3. Our Services:

- Reporting the claim to CMS as required by current regulations (typically done before settlement is completed).
- Obtaining from CMS a conditional payment letter showing any Medicare payments made for treatment of the claimant related to the underlying claim injury (typically done before settlement is completed).
- Auditing the conditional payment listing for treatment for unrelated conditions, challenging any unrelated conditional payments and requesting a revised conditional payment listing (typically done before settlement is completed).
- Negotiating compromise of the Medicare lien when requested and when appropriate (typically done before settlement is completed).
- Providing CMS with attorney fee and cost information for appropriate reduction in Medicare lien amount and obtaining from CMS a final conditional payment demand letter (done after the settlement is completed).

4. What we need from you:

- A completed **New File Referral** form if not already provided (see form attached.)
- Your fee payment.
- Signed **Consent to Release** and **Proof of Representation** forms (attached.)
- Once the underlying claim has been settled, a copy of the settlement documents, and information on the attorney fee and costs charged to the claimant.

New File Referral Form

CLAIMANT INFORMATION:

Claimant name: _____

Street address: _____

City/State/Zip: _____

Date of Birth: _____

Social Security No.: _____

Medicare No.: _____

Medicare Entitlement Date (shown on Medicare card): _____

CLAIMANT ATTORNEY:

Name: _____

Street address: _____

City/State/Zip: _____

Phone: _____

Email: _____

INJURY INFORMATION:

Date of Injury: _____

Description of Injury: _____

DEFENSE ATTORNEY:

Name: _____

Firm: _____

Phone: _____

CLAIM INFORMATION:

Name of defendant: _____

Insurer for defendant: _____

Type of claim (WC/Liab/No fault): _____

Name of adjuster: _____

Address of adjuster: _____

SETTLEMENT:

Actual or estimated settlement date: _____

Actual or estimated settlement amount: _____

Actual or estimated attorney fee: _____

Actual or estimated costs: _____

Our Medicare conditional payment and lien resolutions services (flat prepaid fee of \$500):

- We report the claim to Medicare as required by federal regulations.
- We obtain a letter from Medicare showing any conditional payments made.
- We audit conditional payment claim for accuracy and challenge any payments for treatment unrelated to claim settlement.
- We negotiate a lien compromise when requested and when appropriate.
- We provide settlement information and procurement costs to Medicare for appropriate reductions in the lien amount.
- We obtain a final payment demand from Medicare and guide client on closing case with Medicare.

CONSENT TO RELEASE

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:

) Attorney

Name: Christopher R. Gullen

Firm Name: Gullen & Associates pllc

Address: P.O. Box 80457

Rochester, MI 48308

Telephone: (888) 571-5436

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)

I understand that I may revoke this “consent to release information” at any time, in writing.

Medicare Beneficiary Information and Signature / Date:

Beneficiary Signature: _____ Date signed: _____

Beneficiary’s Health Insurance Claim Number (number on your Medicare card): _____

Date of Illness/Injury for which the beneficiary has filed a claim: _____

