PROOF OF REPRESENTATION

I*, Claimant / Full Name),* hereby inform the Centers for Medicare & Medicaid Services (CMS) that I grant the individual(s) listed below the authority to represent me and act on my behalf with respect to my claim, including releasing identifiable health information or resolving any potential recovery claim that Medicare may have in the event of a settlement, judgment, award, or other payment of that claim.

Type of Medicare Beneficiary Representative:

(X) Individual other than an Attorney: Marker 28
444 Broadway, Suite 306
Saratoga Springs, NY 12866

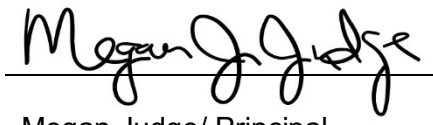
Medicare Beneficiary Information and Signature/Date

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

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

Date of Illness/Injury: _____

Beneficiary Signature: _____Date signed: _____
Claimant / Full Name»

Representative's Signature:  Date signed: _____
Megan Judge/ Principal

Please forward all correspondence to:

Marker 28
444 Broadway, Suite 306
Saratoga Springs, NY 12866
Fax: 833.288.7285