Medicare Beneficiary Information

Beneficiary's Name ____

(Exactly as shown on Medicare Card)

Beneficiary's HICN: __________________________ Date of Injury: ____________________

Proof of Representation

Levinson Axelrod, P.A. represents the above listed Medicare Beneficiary and is authorized to obtain any and all records/information from CMS, its agents and/or contractors.

Type of Medicare Beneficiary Representative: (x) Attorney

Attorney Name: ____________________________ Law Firm: *Levinson Axelrod, P.A.*

□	2 Lincoln Highway, P.O. Box 2905, Edison, NJ 08840	732-494-2727
□	274 Church Street, Belford, NJ 07718	732-787-3200
□	124 Route 31, Flemington, NJ 08822	908-782-6766
□	654 Lacey Road, Forked River, NJ 08731	609-971-1177
□	302 Route 206, Hillsborough, NJ 08844	908-359-0110
□	3641 Route 9 North, Howell, NJ 07731	732-730-9600
□	220 Forsgate Drive, Jamesburg, NJ 08831	732-656-3650

Consent to Release

I, ____, hereby authorize the CMS, its agents and/or contractors to release, upon request, information related to my injury and/or settlement for the specified date of injury to the attorney and law firm listed in the above "Proof of Representation."

The information can be provided on an ongoing basis, from the date of the signature appearing on this form.

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

Medicare Beneficiary Signature

Client's Signature: ______________________________ Date: ____________________

Representative's Signature: _________________________ Date: ____________________

Return to: NGHP, P.O. Box 138832, Oklahoma City, OK 73113; Fax: 405-869-3309