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: ExamWorks Clinical Solutions
2397 Huntcrest Way, Suite 200
Lawrenceville, GA 30043

As the designated Representative for __________________________*(Claimant / Full Name)*, ExamWorks Clinical Solutions has the authority to communicate with CMS and BCRC to obtain conditional payment information and/or receive a recovery demand letter, as well as to identify and/or dispute or negotiate any request for Conditional Payment Reimbursement on the following Medicare Beneficiary:

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: ____________
Christie Britt/Senior VP of Operations

Please forward all correspondence to:

ExamWorks Clinical Solutions
2397 Huntcrest Way, Suite 200
Lawrenceville, GA 30043