

## **PROOF OF REPRESENTATION**

I, \_\_\_\_\_ (print your name exactly as shown on your Medicare card) hereby authorize the MEDVAL, LLC to act on my behalf with respect to my claim for liability, workers' compensation or no-fault insurance, including releasing identifiable health information or resolving any potential conditional payment that Medicare may have made if there is a settlement, judgment, award, or other payment. This may include furnishing conditional payment information and/or a recovery demand letter as well as addressing questions regarding the specific claims included in the conditional payment information, appeal requests or waiver of recovery requests.

**Type of Medicare Beneficiary Representative** (Check one below and then print the requested information):

Beneficiary non-attorney representative: **MEDVAL, LLC**  
**Anna-Marie Sorrento**  
**8860 Columbia 100 Parkway, Suite 308**  
**Columbia, MD 21045**  
**(410) 740-3084**

Attorney - Relationship to the Medicare Beneficiary: \_\_\_\_\_

Guardian - Firm or Company Name: \_\_\_\_\_

Conservator Address: \_\_\_\_\_

Power of Attorney: \_\_\_\_\_

### **Medicare Beneficiary Information and Signature/Date:**

Beneficiary's Name (please print exactly as shown on your Medicare card): \_\_\_\_\_

Beneficiary's Health Insurance Claim Number (number on your Medicare card): \_\_\_\_\_

Date of Illness/Injury for which the beneficiary has filed a liability insurance, no-fault insurance or workers' compensation claim: \_\_\_\_\_

Beneficiary Signature: \_\_\_\_\_ Date signed: \_\_\_\_\_

### **Representative Signature/Date:**

Representative's Signature: \_\_\_\_\_ Date signed: \_\_\_\_\_