# "Consent to Release" Liability Insurance (Including Self-Insurance), No-Fault Insurance, or Workers' Compensation

### Where to find Information on "Consent to Release" vs. "Proof of Representation"

Please refer to the PowerPoint document on this website titled: "Rules and Model Language for 'Proof of Representation' vs. 'Consent to Release' for Medicare Secondary Payer Liability Insurance (Including Self-Insurance), No-Fault Insurance, or Workers' Compensation" for detailed information on

- When to use a "consent to release" document vs. a "proof of representation" document,
- Appropriate content for both documents,
- The need for appropriate documentation when there are two layers of representatives involved (examples: attorney 1 refers a case to attorney 2; the beneficiary's guardian hires an attorney to pursue a liability insurance claim) or when a beneficiary's representative signs a "consent to release" document on the beneficiary's behalf,
- What liability insurers (including self-insurers), no-fault insurers, and workers' compensation entities must have in order to obtain conditional payment information, and
- Use of agents by insurers' or workers' compensation.

#### **General**

A "consent to release" document is used by an individual or entity who does not represent the Medicare beneficiary but is requesting information regarding the beneficiary's conditional payment information. A "consent to release" does not authorize the individual or entity to act on behalf of the beneficiary or make decisions on behalf of the beneficiary.

#### **Model Language**

See attached. Use of the model language is not required, but any documentation submitted as a "Consent to Release" must include the information the model language requests.

Where to Submit a "Consent to Release" document:

Liability Insurance, No-Fault Insurance, Workers' Compensation:

NGHP PO Box 138832 Oklahoma City, OK 73113 Fax: (405) 869-3309

## **CONSENT TO RELEASE**

your attorney or other represen	e used when you, a Medicare beneficiary, want to authorize someone ntative to receive information, including identifiable health informatical services (CMS) related to your liability insurance (including selection claim.	on, from the
authorize the CMS, its agents a	(print your name exactly as shown on your Medicare and/or contractors to release, upon request, information related to my fied date of injury/illness to the individual and/or entity listed below:	injury/illness
	HE FOLLOWING TO INDICATE WHO MAY RECEIVE INFOECTION:	<u>ORMATION</u>
	formation released to more than one individual or entity, you must co	mplete a
☐ Insurance Company	☐ Workers' Compensation Carrier ☐ Other	
Name of entity:		
Contact for above entity:	y	
Address:		
Telephone:		
CHECK ONE OF THE FOLINFORMATION	LLOWING TO INDICATE HOW LONG CMS MAY RELEASI	E YOUR
	n from when you sign and date below.):	
☐ One Year ☐ Two	Years   Other	
	(Provide a specific period of time)	
I understand that I may revoke	e this "consent to release information" at any time, in writing.	
MEDICARE BENEFICIARY	Y INFORMATION AND SIGNATURE:	
Beneficiary Signature:	Date signed:	
Note: If the beneficiary is incapacitate the individual signing on the benefici	ted, the submitter of this document will need to include documentation establishing iary's behalf.	g the authority of
Medicare Health Insurance claim	im Number (The number on your Medicare card.):	
Date of Injury/Illness:		