BCRC NGHP Correspondence Cover Sheet

(Download Acrobat Reader to fill in these documents electronically.)

(*Required)

*Beneficiary's Name: _____

*Medicare ID: _____

*Date of Incident: _____

*Case Identification Number: _____

*Insurer Claim Number: _____

This cover sheet is for your use when mailing or faxing in correspondence to the Benefits Coordination & Recovery Center (BCRC). Please retain a COPY of this cover sheet for any future correspondence. Please indicate the type of correspondence you are submitting to the BCRC to facilitate routing.

Check all that apply:

- ☐ Payment enclosed
- ☐ Settlement information
- ☐ Retainer agreement or other authorization documentation
- ☐ Other _____

Note: A Conditional Payment Letter is sent automatically within 65 days of this letter, or as soon as the information is available. **Separate requests for initial Conditional Payment Amounts will not make Conditional Payment information available sooner.**

In order to accurately associate claims to your case, please include a description of the injury or illness (i.e., knee, physical therapy, slip and fall, lumbar injury….).

_____

_____

_____

_____

Submit correspondence to the BCRC address listed below:

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

NGHP
PO Box 138832
Oklahoma City, OK 73113

Consent to Release or Proof of Representation Document

In order for BCRC to respond to a request, we must have the proper authorization on file. Refer to the presentation and model language on the CMS.gov website for more detailed information and requirements for "Proof of Representation vs. Consent to Release." Include documentation to support the authorizing representative that can sign on behalf of the beneficiary/beneficiary's estate (i.e., Power of Attorney, Letters of Testamentary, etc.) if applicable.

(*Required)

*Beneficiary's Printed Name (as shown on Medicare Card): _____

*Beneficiary's Medicare ID: _____

*Date of Injury/Illness: _____

*Beneficiary's Signature: _____ *Date: _____

Proof of Representation allows the BCRC to communicate with and provide information to a Medicare beneficiary's representative. (Insert name, address, and phone number of the representative.)

I, _____, appoint _____

_____

_____

as my representative, and to act on my behalf, for the date of incident listed above.

Organization who may disclose the information: **BCRC/Medicare**

Type of Representation:

Individual other than Attorney: _____

(Check one) ☐ Attorney ☐ Guardian ☐ Conservator ☐ Power of Attorney

Representative's Signature: _____ Date: _____

Consent to Release allows an entity who does not represent the beneficiary the ability to request information regarding the beneficiary's conditional payments.

I, _____ hereby authorize CMS, its agents and/or contractors to release, upon request, information related to my injury/illness and/or settlement to the individual or entity listed below (check one):

☐ Insurance Company ☐ Workers' Compensation Carrier ☐ Other: _____

Name of individual/entity: _____

Address: _____

City, St., ZIP Code: _____

Phone Number: _____

This authorization will expire (check one):

☐ 1 Year ☐ 2 Years ☐ Other _____ (Specify period of time)