PROOF OF REPRESENTATION AUTHORIZATION FORM

I, ______________________, (Medicare Beneficiary) designates the following company as my representative, ***who is a non-attorney***, to assist with regard to my conditional payment summary from BCRC.

SPECIALTY ALLOCATIONS, INC
555 Winderley Place, Suite 300
Maitland, Florida 32751

This authorization offers **Specialty Allocations, Inc.**, the designated representative to communicate directly with the Centers for Medicare and Medicaid services and BCRC in order to dispute and/or negotiate any requests for Conditional Payment Remuneration for the following Medicare beneficiary.

Medicare Beneficiary Information and Signature/Date:

Medicare Health Insurance Claim Number (HICN-The number on your Medicare card):

____

Date of Illness/Injury:

____

Beneficiary's Signature:

____

Date Signed:

____

Authorized Representative Signature/Date:

Specialty Allocations Representative's Signature

____

Date Signed:

____