JND LEGAL ADMINISTRATION

Proof of Representation

The signatory Beneficiary informs the Centers for Medicare & Medicaid (CMS) that they authorize the identified representative to represent them and act on their behalf with respect to any claims for liability insurance, no-fault, or worker's compensation, including releasing identifiable health information or resolving any potential recovery claim that Medicare may have if there is a settlement, judgment, award, or other payment. The representative agrees to represent the undersigned Beneficiary and has been retained by the Hadden Settlement Fund Administrator.

Representative Type:	JND Legal Administration Representative Name/Company PO Box 91351 Address Seattle, WA 98111 City, State, Zip 206-709-6440 Telephone Number
☒ Individual Other Than Attorney ☐ Attorney ☐ Guardian* ☐ Conservator* ☐ Power of Attorney*	

Claimant Information:

Claimant's Name (Required): _____

Claimant's Medicare Number, if available, or Social Security Number (Required): _____

Date of Illness/Injury (Required): _____

Claimant Signature* (Required): _____ Date Signed (Required): _____

*If incapacitated or deceased, a legal representative needs to sign and submit documentation.

Representative Signature: Shandarese Garr 1.29.2024 On behalf of JND

JND LEGAL ADMINISTRATION

Consent and Authorization for Use and Release of Information

I authorize my insurance provider (Medicaid, TRICARE, or Veterans Affairs) to disclose my personal health information to JND Legal Administration. I understand this is voluntary, made to confirm my directions, and has no effect on any benefits to which I may be entitled.

Name (Required) _____

Date of Birth (Required) _____ Date of Injury/Illness (Required) _____

Health Insurance Claim Number or SSN (Required) _____

Personal Health Information to be Disclosed

This consent authorizes the release and use of information regarding healthcare claims and other information related to my injury and/or illness and the medical care performed or paid for by the lien holder, including, but not limited to: medical records (including electronic), diagnosis and other procedural codes, enrollment status, and payments made. This also applies to access to online websites containing such information. This may include data on certain conditions such as HIV/AIDS, Mental Health and Alcohol and Substance Abuse.

Entity Authorized to Receive and Use

I authorize the disclosure and use of non-public personal health information described above to **JND Legal Administration**, its employees, agents, affiliates, or representatives.

JND Legal Administration
PO Box 91351
Seattle, WA 98111

The entity described above is authorized to receive, negotiate and resolve any and all information related to the above-described claim from any healthcare lien holder, contract representative, and/or private plan administrator. I understand that this information may be re-disclosed by them and may no longer be protected by federal or state law.

Revocation Right

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance. I understand that my treatment, payment, enrollment or benefit eligibility may not be conditioned upon signing.

Effective Period

If not previously revoked, this consent/authorization will expire two (2) years after all claims, if any, have been resolved, unless indicated differently below:

_____

I specifically consent to and authorize the disclosure and disclosure described above.

_____ _____

Signature of Claimant or Legal Representative (Required) Date (Required)

_____

Printed name and/or relationship of legal representative (if you are a representative, please attach a copy of the legal document that verifies that you are a representative)

Privacy Statement

The information to be collected in regard to this consent will be used in furtherance of, and to comply with, Section 1862(b) of the Social Security Act (42 U.S.C. 1395y). This information will be used to determine whether any services received are covered by Medicare or Medicaid, or whether a no-fault, automobile, liability insurer, or any other persons(s) may be responsible for such payment.

A photocopy or facsimile of this form shall be valid and given the same force and effect as the original.