(Please put your letterhead here)

LETTER OF AUTHORIZATION

(Name of Insurance Company) _____ appoints the following company as their agent:

Marker 28
444 Broadway, Suite 306
Saratoga Springs, NY 12866

As the designated Agent for (Name of Insurance Company)_____, Marker 28 has the authority to communicate with CMS and MSPRC in regards to obtaining conditional payment information and/or a recovery demand letter, as well as disputing/negotiating any request/demand for Conditional Payment Reimbursement on the following Medicare Beneficiary:

Beneficiary's Name: _____

Beneficiary's HICN: _____

Date of Illness/Injury: _____

Insurer Address: _____

Insurer Phone: _____

_____
Adjuster Signature Date

_____
Printed Name

_____
Monica Mohring Date
Marker 28

EXPIRES 3 YEARS FROM DATE OF SIGNATURE