SANDERSON FIRM
PLLC

PROOF OF REPRESENTATION

I, _____, hereby inform the Centers for Medicare & Medicaid Services (CMS) and/or the Department of Treasury (DOT) that I grant the individual(s) listed below the authority to represent me and act on my behalf with respect to my claim, including releasing identifiable health information or resolving any potential recovery claim that Medicare may have in the event of a settlement, judgment, award, or other payment of that claim.

Type of Medicare Beneficiary Representative:

(X) Attorney/Law Firm: Sanderson Firm PLLC
1001 3rd Ave. W., Suite 400
Bradenton, FL 34205

Medicare Beneficiary Information and Signature/Date

Beneficiary's Name (please print exactly as shown on Medicare card): _____

Beneficiary's Health Insurance Claim Number (number on Medicare card):_____

Date of Illness/Injury: _____

Beneficiary Signature:_____Date signed: _____
Claimant / Full Name

Representative's Signature:_____Date signed: _____
Heather Sanderson, Esq., President

Please forward all correspondence to:

Sanderson Firm PLLC
1001 3rd Ave. W., Suite 400
Bradenton, FL 34205