**Note: This letter must be placed on letterhead of the**

**liability, self-insured, no-fault or workers’ compensation insurer**

**Letter of Authority**

#### [Insert Current Date]

#### Commercial Repayment Center — NGHP P.O. Box 93965 Cleveland, OH 44101

Beneficiary:

Medicare ID Number/SSN:

Date of Incident:

Dear CRC:

[Insert Insurer Name] has appointed **Genex Services, LLC,** as our agent to work on our behalf to obtain conditional payment information as well as address Medicare Secondary Payer recovery claims asserted against us with respect to the above Medicare beneficiary. **Genex Services, LLC,** has authority to work on our behalf for two years from the date of this letter or until [Insert Insurer Name] specifically revokes this authority in writing.

Please feel free to contact me if any additional information is needed.

Sincerely,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date Signed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurer Representative Name**

***Telephone Number***

***Email address***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Signed: \_\_\_\_\_\_\_\_\_\_\_\_**\_\_

**Genex Services, LLC**

**Medicare Set-Aside Services**

**440 East Swedesford Road, Suite 1000**

**Wayne, Pennsylvania 19087**

**Phone: (877) 674-5175**