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PROOF OF REPRESENTATION

Type of Medicare Beneficiary Representative (Check one below and then print the requested information):

- Individual other than an Attorney: Name: _____
- X Attorney* Relationship to the Medicare Beneficiary: Attorney

- Guardian* Firm or Company Name: Ramsay Law Firm, PA

- Conservator* Address: PO Box 481210, Charlotte, NC 28269

- Power of Attorney* Phone: 704-376-1616

Medicare Beneficiary Information and Signature/Date:

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

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

Date of Illness/Injury for which the beneficiary has filed a liability insurance, no-fault insurance or workers' compensation claim: _____

Beneficiary Signature: _____ Date signed: _____

Representative Signature/Date:

Representative's Signature: _____

Date signed: _____