## Self-Calculated Conditional Payment Amount Model Language All Information Is Required Unless Inapplicable

## Self-Calculated Conditional Payment PO Box 138880 Oklahoma City, OK 73113

Dear Benefits Coordination & Recovery Center (BCRC):

I expect to receive a physical trauma-based liability insurance settlement for approximately <u>and I would like to calculate my Final Conditional Payment Amount (CPA). I have</u> calculated my Final CPA to be <u></u>, which is supported by the documentation I am enclosing with this letter.

Beneficiary Name: \_\_\_\_\_ Date of Incident: \_\_\_\_\_

Medicare Number:

I certify that the following statements are true:

- I expect to receive a *liability insurance* settlement for \$25,000.00 or less for a physical trauma based injury. (The injury did not relate to ingestion, exposure, or a medical implant.)
- My incident/injury occurred at least six (6) months ago.
- My medical treatment related to my case is finished and I am able to demonstrate this in one of two ways: (*Please check one.*)

☐ I have included a physician attestation; OR

- ☐ I certify that I have not had care related to my case within the last 90 days and expect no further care.
- I have included all Medicare covered and reimbursable items and/or services related to my case (what was claimed or released). I have not knowingly disregarded related items or services that have been or will be provided through the date of settlement.
- I understand that if my self-calculated amount is accepted, I will be required to give up my right to appeal the amount or existence of the debt.
- I have not received and do not expect to receive any other *liability insurance* settlements, judgments, awards, or other payments related to the incident referenced above. If I receive any, I will notify Medicare because Medicare may have an additional recovery claim.

Sincerely,

Beneficiary Signature

Date: \_\_\_\_\_

Attorney or Representative Printed Name

Date:

\* Attorney or Representative Signature

Check here if you do not have an attorney or other representative.

<sup>\*</sup> If attorney or representative signs and the beneficiary does not sign, a proper authorization must be on file or included with the Self-Calculation documents in order for the Self-Calculated Amount to be reviewed.

## Self-Calculated Conditional Payment Amount Proposal Cover-Sheet All Information Is Required Unless Inapplicable

Please place a Y (yes, related to the case) or N (no, not related to the case) next to each claim on Medicare's Payment Summary Form. Add any additional claims not already included on the sheet. Include a TOTAL labeled Self-Calculated Conditional Payment Amount. Provide a brief description of the injury and an explanation for any claims you labeled with a "N" as not being related to the case.

**Brief Description of Injury:** 

**Explanation for Disputed Claims:** (*If you have more than one explanation, please provide the date range for each explanation.*)

Example: Claims with dates between January 1, 2010 and September 13, 2010 were for back surgery but my case is for a sprained knee.

