**Letter of Authority**

**CARRIER/SIF/TPA/EMPLOYER** appoints the following company as their agent:

**LEGACY CLAIM SOLUTIONS**

**1106 Second Street, #473**

**Encinitas, CA. 92024**

**877-448-2772**

Dear CMS/CRC/BCRC:

**Legacy Claim Solutions**, as our Claim Resolution Vendor, has the authority to communicate with CMS/CRC/BCRC in regards to obtaining the conditional payment information and/or the recovery of demand letter, as well as disputing any request for conditional payment reimbursement on our behalf.

CHECK ONE OF THE FOLLOWING TO INDICATE HOW LONG CMS MAY RELEASE YOUR INFORMATION (The period you check will run from when you sign and date below.):

( ) One Year (X) Two Years

I understand that I may revoke this authorization at any time, in writing.

**Beneficiary Name:**

**Beneficiary Address:**

**Beneficiary DOB:**

**Beneficiary HICN/SS:
Claim Number:**

**Date(s) of Injury:**

**Injury Description:**

**Employer:**

**Employer Address:**

**Representative Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Representative Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Representative Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Assignee Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Assignee Signature:­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Assignee Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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