Precision Resolution, LLC Medicaid Lien Resolution
Letter of Engagement

So that Precision can best serve you, your firm and your client, please complete the following steps and return the enclosed/attached documents to our offices via email at intake@precisionlienresolution.com.

- **Page 2**: New Case Intake Form;
- **Page 3**: HIPAA Authorization form authorizing plan/collection agent's release of information to Precision Resolution, to be signed by your client; and
- **Page 4-5:** Precision Resolution Medicaid Lien Resolution Retainer Agreement: to be reviewed and signed by you. Once the executed form is forwarded to Precision, our attorney representative will execute same.

Additionally, if you have received any correspondence from the State Medicaid agency, HMS, Inc., or other lienholder related to the submitted matter(s), please forward all correspondences received to our attention with the above referenced documents.

Upon Precision's receipt of the above required documents, an invoice will be generated and sent to your attention. We kindly ask that all invoices be paid upon receipt. Any additional invoices for the reduction of a lien amount negotiated will be generated and forwarded to your attention at the time of resolution.

Please do not hesitate to contact our offices with any further questions.

Thank you for your confidence in Precision Resolution.

Best regards,

Precision Resolution, LLC
3686 Seneca Street
Buffalo, NY 14224
(T) 888-961-LIEN
(F) 716-712-0400
intake@precisionlienresolution.com
PrecisionLienResolution.com

Precision Resolution, LLC Tax ID: 27-4860890

When dealing with compliance and lien resolution matters, always demand Precision.

PRECISION RESOLUTION

New Case Intake Form

Date of Request ______/_______/________

So that Precision may begin processing your file immediately, please submit this completed form, along with any/all additional authorization forms to *intake@precisionlienresolution.com*

Attorney Information

Name ____

Phone ______________________ Fax ______________________

Firm ____

Address ____

City _________________________ State __________ Zip ____________

Attorney Email ____

Paralegal/Associate Contact _________________________________

Paralegal/Associate Email __________________________________

Claimant Information

Name ____

Gender ☐ Female ☐ Male

SSN _______________________ DOB ______/_________/_______

Address ____

City _________________________ State __________ Zip ____________

Phone ____

Has claimant lived in another state since date of injury? Yes* ☐ No ☐

*If yes, what state(s)? _____________________________________

Settlement Information

Has this case settled? ☐ Yes ☐ No Settlement Amount $________________

Settlement/Anticipated Settlement Date ________/_________/__________

Comments

Nature of Injury

DOI_____/_______/________ DOD (if applicable) _____/_______/________

Specific Nature of Accepted Injuries

Still Treating ☐ Yes ☐ No Last Treatment Date _____/_______/_______

Known Pre-Existing Conditions

Nature of Claim (check all that apply)

☐ Motor Vehicle Accident

NO-FAULT

No Fault Policy? ☐ Yes ☐ No

No Fault Carrier Full & Proper Name

APIP

Might APIP be Obligated to Pay Medicals? ☐ Yes ☐ No

APIP Carrier Full & Proper Name

Policy Limit $____

☐ Medical Malpractice

☐ Nursing Home Negligence

☐ Slip & Fall

☐ Exposure ________________________

☐ Product Liability ____________________

☐ Other______________________________

LIABILITY

Liability Carrier Full & Proper Name

Policy Limit $____

WORKERS' COMP

WC Carrier Full & Proper Name

Policy Limit $____

OTHER BENEFITS RECEIVED	☐ Social Security Disability Insurance	Start _____/_____/____ End _____/_____/____	☐ Supplemental Security Income	Start _____/_____/____ End _____/_____/____	☐ Other ______________________	Start _____/_____/____ End _____/_____/____

Services Requested Check all that Apply		Claimant Receiving (Past or Present)	Case Reported to Agency	**Relevant Claim Information** Please submit a copy of any/all correspondences with agency and claimant's insurance cards along with this and all other authorization forms to intake@precisionlienresolution.com
☐	Medicare Conditional Payment (Parts A/B)	☐	☐	HIC # ______________________ Entitlement Date _____/_______/________
☐	Medicare Advantage (Parts C/D)	☐	☐	Insurance Company Name ________________ Group/ID # ________________
☐	Medicaid	☐	☐	Medicaid # ______________________ State(s) ______________________
☐	Self-Funded ERISA or Other Private Healthcare	☐	Plan Docs Requested? *Yes No	Insurance Company Name ______________________ Group/ID # ______________________ If Employer-based Health Plan, specify employer name ______________________ *Please provide Plan Document or Summary Plan Description if available.
☐	TRICARE	☐	☐	Treatment Facilities ______________________ Sponsor SSN______________________
☐	Veteran's Administration	☐	☐	Treatment Facilities ______________________ Sponsor SSN______________________

Additional Comments

Authorization for Use and Disclosure of Protected Health Information
Pursuant to the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA) (45 C.F.R. §164.508)

In Reference To:

Patient Name	Date of Birth	Social Security Number

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. Information disclosed under this authorization might be redisclosed by the recipient, and this redisclosure may no longer be protected by federal or state law.

PURPOSE OF AUTHORIZATION:
To provide a full disclosure of any information to Precision Resolution, LLC, its agents, employees, affiliates, subsidiaries, or representatives is to enable an assessment and evaluation to prepare a Future Medical Cost Projection, and/or Medicare Set-Aside Arrangement or commence a lien resolution action. Note that the claimant may revoke this Authorization at any time by written notice to Precision Resolution, LLC, its agents, employees, affiliates, subsidiaries, or representatives, but that any revocation shall have no effect on actions which have been taken prior to receiving. Any personal health information that the Claimant authorized to disclose may be subject to redisclosure and no longer protected by law.

ENTITIES AUTHORIZED TO RELEASE THE INFORMATION:
Healthcare Provider, Insurer, Collection Agent:

ENTITIES AUTHORIZED TO RECEIVE, USE, AND DISCLOSE THE INFORMATION:
Precision Resolution, LLC, its agents, employees, affiliates, subsidiaries, or representatives.

Mailing Address:
Precision Resolution, LLC
3686 Seneca Street
Buffalo, NY 14224

LIST OF INFORMATION TO BE RELEASED:
Entire Medical Record, including patient histories, office notes (except psychotherapy notes), lab/test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

Name of Entity to Release Information:
Address of Entity to Release Information

I have read and understand the contents of this Authorization and have had the opportunity to discuss same with counsel of my choice. The contents of this Authorization confirm, and are consistent with, my authority, instructions, or directions to Precision Resolution, LLC and their Employees and Representatives and I understand that by executing this Authorization, I am authorizing Precision Resolution, LLC and their Employees and Representatives to use and disclose, as permitted and outlined herein, certain nonpublic information. All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the forms.

Claimant/Injured Party Signature	Claimant/Injured Party Name	Date

OR

Personal Representative Signature	Print name, and Title (based on authority to act) (i.e.,guardianship /conservatorship letters of authority, powers of attorney, etc. attached)	Date

PRECISION RESOLUTION, LLC MEDICAID LIEN RESOLUTION RETAINER AGREEMENT

Date:

This Lien Resolution Agreement, hereinafter referred to as "Agreement", by and between ____**,** with an office located at ____,
hereinafter referred to as the **"Attorney"**, and **Precision Resolution, LLC**, with an office located at 3686 Seneca Street, Buffalo, New York, 14224, hereinafter referred to as "**Precision.**"

Subject Matter of Agreement. The Attorney represents ________________________, a client that has been injured or suffered damages as a result of an accident or injury occurring on or about __________________________. The Attorney on behalf of the aforementioned client has received notice of a claim(s), right(s) of subrogation and/or lien(s) from:

Name of Entity	Type of claim, right of subrogation or lien (i.e. Medicaid)

Lien Resolution Services. The Attorney agrees to retain the services of Precision to attempt to reduce or eliminate the claim(s), right(s) of subrogation, and/or lien(s) on the aforementioned client's behalf. The Attorney specifically authorizes Precision to correspond with any alleged claim holder(s) and/or lien holder(s) and/or their legal representative to discuss and negotiate a resolution on behalf of your client. All offers/ counteroffers for settlement shall be first approved by the attorney and any such resolutions will be negotiated pending the final approval of the Attorney. Precision will verify the legal validity of the claim, right and/or lien. At the conclusion of your case, Precision will obtain an appropriate Release and/or confirmation of receipt of payment in full satisfaction of the claim, right and/or lien. The Attorney agrees to fully cooperate with Precision and timely provided any and all information and documents to assist in the performance of the services agreed to herein where necessary should it be necessitated. The Attorney shall provide to Precision a duly executed Authorization from the client authorizing the release of medical information to Precision and the above-named entity solely for purposes of discussing and negotiating a resolution to the claim, right and/or lien in accordance with the terms of this Agreement as may be necessary.

Confidentiality. Some/all documents submitted to Precision Resolution, LLC may be shared with ____________________________________, and/or any collection agents working on their behalf, including but not limited to ____, throughout Precision's retention on this matter. Further, Precision's submissions to such entities for the the purposes of reducing purported recovery amounts related to the retained matter are confidential. Therefore, Precision will not disclose them to any entity other than those that are referenced above. This will acknowledge that, in order to protect privacy and confidentiality and/or to protect against conflicts of interest, neither the Attorney nor the plaintiff/claimant will receive copies of Precision's submissions.

Lien Resolution Fee. The Attorney agrees to pay Precision a fee to seek a reduction or elimination of the claim, right and/or lien asserted against the aforementioned client's settlement proceeds as follows:

Services	Fee
Initial Retainer Amount For the collection, research, review, drafting and submission of documents required to engage in a challenge of the lien amount.	Initial retainer of **$1,000.00** due upon submission of this executed retainer agreement.
Successful Reduction of Lien Claim Any reduction of the lien amount by Precision after review of the collected documents and prior to any litigation or commencement of action related to the lien.	***15% of the reduction of the lien amount.** Plus costs for Applicable Filing/Court Fee, Printing of Brief(s), and reasonable travel expenses.
Successful Reduction by Way of Legal Action/Litigation of Lien Commencement of action or Defense of Claims related to the lien	***25% of the reduction of the claim** Plus costs for Applicable Filing/Court Fee, Printing of Brief(s), and reasonable travel expenses.

*This fee applies to reductions of the lien amount as a result from a formal challenge of a lien. Statutory reductions for attorney's fees and procurement costs, etc. is not a billable service rendered by Precision. Further, fees for services rendered in the event of Appellate Review shall be discussed and agreed upon by Precision and Attorney in the event that such measures are required.

Fee Payment. Precision Resolution, LLC's ***retainer fee of $1,000.00 is due, in entirety, prior to the commencement of any service rendered.*** The Attorney agrees to issue payment to Precision within 30 calendar days of the date of Precision's submission of the final invoice, to the address above. Any other additional retainers must be paid prior to the initiation of that respective level of service.

The undersigned hereby agree to the terms of the services to be rendered as further set forth above.

We look forward to working with you and your office.

ATTORNEY

_________________________ _________________________

Date

PRECISION

_________________________ _________________________

Paul K. Isaac, Esq.
Managing Partner, Chief Counsel
Precision Resolution, LLC

Date