To ALL Oregon SHIBA Clients

Disclosure Statement

The Oregon Senior Health Insurance Assistance (SHIBA) Program is sponsored by the Oregon Insurance Division of the Department of Consumer and Business Services in order to make information on health insurance more widely available to, and understandable for, Oregonians with Medicare.

SHIBA, and SHIBA Counselors CAN:

- Provide you with information on Medicare benefits, Medicare Supplement plans, Medicare Advantage plans, Prescription Drug Plans, Long-Term Care insurance and other kinds of health insurance programs and policies.
- Give you helpful information on how you can compare insurance products and the services they provide.
- Assist you in analyzing the different kinds of policies and insurance programs in which you have an interest.
- Assist with applications for “Extra Help” prescription drug subsidy, research Patient Assistance Programs and make appropriate referrals to agencies that provide help with Medicare costs.
- Help you to identify resources (government offices, public service agencies or other information resources) you may need to consult before making decisions.

SHIBA counselors have been trained to deal with commonly raised questions in these areas.

SHIBA, and SHIBA Counselors CANNOT:

- Advise you on the purchase, renewal or termination of specific insurance products or programs.
- Endorse any particular insurance policy, program or company.
- Provide legal advice.
- Make decisions for you.

Should you have further questions regarding SHIBA, please call 1-800-722-4134.

By my signature below, I acknowledge that SHIBA and /or SHIBA Volunteers are providing service to me based on the above statements.

Client Signature _____ Date_____

Counselor Signature _____ Date_____

IF NEEDED, PLEASE COMPLETE:

_____ **(initial here)** Furthermore, I authorize the SHIBA Sponsoring Organization (_____ _____) to obtain information as necessary directly from my hospital, physician or other supplier of medical services or supplies to complete the filing of my medical claim to Medicare or of _____ other insurance plans. This authorization shall remain valid for 90 days from the date of signature unless earlier revoked in writing.

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved OMB
No. 0938-0950

Appointment of Representative

Name of Party	Medicare or National Provider Identifier Number

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint this individual, _____ to act as my representative in connection with my claim or asserted right under title XVIII of the Social Security Act (the "Act") and related provisions of title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code

Section 2: Acceptance of Appointment

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____

(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of the Department of Health and Human Services.

Signature	Date

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date