Rhode Island Senior Medicare Patrol (SMP)
Release of Information Form
RE: Medicare / Medicaid Billing Issue

Date: Click or tap to enter a date.

Name of Beneficiary: Click or tap here to enter text.

Dear: Click or tap here to enter text.

You have contacted **Rhode Island SMP** at Click or tap here to enter text. for assistance regarding a health care error, fraud, or abuse issue. In order for us to assist you, please complete and sign this *Release of Information Form* on page two (2) of this notification so that we may handle your request or refer it to the proper investigative agency, if necessary. The beneficiary is not required to sign this release, however, without your signed consent we will not be able to forward your concern/issue to the appropriate agency for further investigation. For more information on SMPs, please visit the National SMP Resource Center at: https://www.smpresource.org/Content/Resources-for-SMPs/SMP-Resource-Center.aspx. Thank you.

Once you have completed and signed the form, please send it back by:

Regular Mail (address is listed below) ☐

Email (email address is listed below) ☐

Fax @ #: Click or tap here to enter text. ☐

RI SMP Authorized Agent Information:

Name of SMP Team Member: Click or tap here to enter text.

Phone #: Click or tap here to enter text. Email address: Click or tap here to enter text.

Name of RI SMP Regional Agency: Click or tap here to enter text.

Address of RI SMP Regional Agency (city/state/zip): Click or tap here to enter text.

NOTES: Click or tap here to enter text.

This project was supported, in part by grant number 90MPPG0018-03-00, from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official Administration for Community Living policy." (HHS Grants Policy Statement: http://www.hhs.gov/grants/grants/grants-policies-regulations/index.html).

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RELEASE OF INFORMATION

To be completed by the Beneficiary or their authorized representative

I, (Print Your Name Here) _____

hereby authorize RI SMP, or its authorized agent, to discuss my healthcare complaint/issue with the appropriate authorities for the purpose of investigating and resolving possible error, fraud, or abuse. I understand that, except for actions already taken, I may revoke this authorization at any time. I also understand that a photocopy of this authorization has the same effect as the original.

Signature of Beneficiary (or authorized representative): _____

Date: _____

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