NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Medicaid & Long-Term Care

MEDICAID ESTATE RECOVERY

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Request for Certification of No Recoverable Amount

Neb. Rev. Stat. §68-919(4)(e)

The information to be released pursuant to this authorization is limited to records or information for or in the possession or control of DHHS.

Decedent's Name *(Last, First MI)* :	**Decedent's Date of Birth:**	**Decedent's Date of Death:**	**Decedent's SSN:**

Decedent's Marital Status at Death ○ Married ○ Widowed ○ Divorced ○ Never Married	**Spouse's Name** *(Widowed/Married Only)*	**Spouse's Date of Birth:**	**Spouse's Date of Death:**	**Spouse's SSN** *(if known):*

Name *(Last, First MI)* **of Requester's Signature below:**			**Disclose to** *(if someone other than Requester)* **:**		
Company/Firm *(if applicable)*			**Company/Firm** *(if applicable)*		
Address:		**P.O. Box:**	**Address:**		**P.O. Box:**
City:	**State:**	**Zip Code:**	**City:**	**State:**	**Zip Code:**
Phone:	**e-mail address:**		**Phone:**	**e-mail address:**	

This authorization (unless revoked earlier in writing) shall terminate on _____

(MUST HAVE DATE OR EVENT FILLED IN)

By signing this authorization, I acknowledge that the information to be released may include material that is protected by federal or state law including benefit or enrollment information. My signature authorizes release of this information. I also understand that I may revoke this authorization for disclosure of Protected Health Information (PHI) at any time by submitting a written request in accordance with the then current DHHS Notice of Privacy Practices and it will be honored with the exception of information that has already been released.

Federal law requires us to inform you that DHHS will not condition payment or eligibility for benefits on whether this authorization is signed. Information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient and may no longer be protected by law.

Signature of Requester:	**Printed Name of Requester:**	**Date Signed:**

Type of Authority

○ (Successor) Trustee OR ○ their Legal Counsel

○ Personal Representative OR ○ their Legal Counsel of Record

○ Surviving Spouse

○ Other *(explain)* _____

Please have the **SIGNATURE** of Requester **NOTARIZED** if the information is to be disclosed to someone other than the Applicant/Requester *(i.e., Notary not required if Certification is to be sent to Requester)*

STATE of _____ County of _____

Subscribed and sworn before me on this _____ day of _____, 20___

My commission expires on _____, 20____

_____
Notary Public Signature

This space reserved for
Notary Seal/Stamp ==>

Return this completed form with an attached copy of legal authority to act for the decedent, such as (a) pertinent provisions of the applicable trust appointing the trustee or successor trustee; or (b) court-issued letters of Personal Representative; or (c) court-ordered appointment of trustee; or (d) a court order authorizing disclosure of the decedent's Protected Health Information (PHI) *as the fiduciary or as Legal Counsel for the (Successor) Trustee or Personal Representative)* to:

dhhs.medicaidestaterecovery@nebraska.gov OR **DHHS - Estate Recovery**
P.O. Box 95026
Lincoln, NE 68509-5026

If you need assistance, contact Estate Recovery at: (402) 471-9126
(402) 471-7727

OR

Rev: 19 June 2019