Assignment of benefits form

Practice name: _____ Date: _____
Address: _____ Patient: _____
City, State, Zip: _____ ID: _____

I, _____, understand that services rendered to me by _____ are my Financial responsibility and that the provider will bill my insurance company, _____ as a courtesy. I authorize my insurance company to pay my benefits directly to _____ and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above- mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and coin insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by _____.

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim .

I also understand that should my insurance company send payment to me, I will forward the payment to _____ within 48 hrs. I agree that if I fail to send the payment to the provider and them Are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to Retrieve their monies. In the event patient receives any check draft or other payment subject to this agreement, I Will immediately deliver said check, draft or payment to provider and bring any balance owed by patient to provider immediately due and payable.

To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I Authorize _____to facilitate payment utilizing the credit card number on file to resolve the balance. A photocopy of this assignment shall be considered as affective and valid as the original.

I authorize the provider to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and personally will be active in the resolution of claims delay or unjustified reductions or denials.

Dated_____ Witness_____

_____ _____
Signature of policy holder Patient or guardian