Perimeter Outpatient Surgical Associates/Perimeter Orthopaedics, PC

Assignment of Benefits Form

I, _____ (Print Name), having healthcare benefits for medical necessity services through my employer, (Employer Name) _____, Medicare, Medicaid, or individual Plan; including title XVIII of the Social Security Act or related provisions of title XI of the Act, I hereby appoint as my authorized representative, and assign to the above listed healthcare provider and/or designated business associate my rights, title, and interest in and to, and relating in and to the recovery of, any and all health care and/or surgical benefits otherwise payable to me or to receive coverage for medical care and/or benefits for which I am entitled to receive under my plan or policy, including major medical services rendered, ordered or requested by a healthcare provider as designated to render medical treatment or services. I specifically appoint as my authorized representative, the above provider and/or designated business associate to: File and prosecute any required appeal or grievance with my health plan and/or health insurer for any denial of: medical tests, treatment or surgical care or payment of pre or post-service medical claims submitted by my treating physician or other medically related provider; and to exert or receive any other rights or benefits entitled under my health plan or policy. I specifically authorize my authorized representative to name me and the patient, if I am executing this document on the patient's behalf, as plaintiffs in such litigation or arbitration against my health plan and/or health insurer or otherwise pursue claims on my behalf. I hereby also assign to the provider listed above or other applicable medically related provider, any right wholly in my stead to recover its full billed charges and any expenses and fees incurred for damages, punitive damages and/or penalties. This authorization includes the right to litigate under civil rights remedies provision of ERISA; Receive, release or discuss my personal health information or relevant medical records with my Plan Administrator, health plan and/or health insurer. I release or discuss my personal health information or relevant medical records with my Plan Administrator, health plan and/or health insurer. I specifically authorize any law firm appointed by my authorized representative to file litigation or arbitration on my behalf and on behalf of my authorized representative with respect to any or all of the items listed above. I hereby authorize the above listed provider, other medically related provider or facility, insurance company, third party administrator, plan sponsor, employer, government agency investigative or security agency or any other person or organization having any relevant records, documents, knowledge or information concerning my claim for benefits, my health, or request for medical treatment as it may relate to my pre or post-service claim for benefits; to release such information to my authorized representative as appointed; to exchange such information with any of the named parties where such exchange is necessary for the proper adjudication and processing of my claim for benefits. If any outside policies or consultant were used or relied on by my Plan or health insurer to perform an adverse benefit determination or in the handling of my pre or post service claim for benefits or any appeal requests, my health plan or health insurer is directed to provide my authorized handling of my pre or post service claim for benefits or any appeal requests, my health plan or health insurer is directed to provide my authorized representative with a legible copy of any said policy relied upon, all complete claim files, all investigative files, all relevant documents, data and communications associated with any pre-service or post-service claim for benefits and any appeals submitted, to include all names, credentials, qualifications and employer of the person(s) who performed or had any bearing on the adverse benefit determination and appeal requests; the name, credentials and qualifications of any consultant(s_ and any and all documents information provided by said consultant(s) relied upon by my health plan or health insurer for the adverse benefit determination and any subsequent determinations. This authorization includes the discovery of any and all relevant plan and other documents, data, policies, protocols and other information relied upon and/or relevant to my pre or post-service claim for benefits. I understand that my Health Plan, TPA, Insurance Company or my third party involved in handling my claim for benefits is required to accept and honor this legally binding assignment of benefits in full compliance of all applicable governing laws. I understand to the full extent permissible under governing law that I have the right and authority to direct where benefit payment for claim submittals for services rendered is sent. I hereby instruct and direct my Health Plan or Health Insurance issuer to pay <u>all</u> healthcare or plan benefits as entitled, directly to the healthcare provider submitting my claim for benefits. If my current policy or Plan prohibits direct payment to the medically related provider rendering services or prohibits Health Insurance issuer to provide specific Plan documentation marking such proof of non-assign ability clause to myself and my authorized representative. Such <u>proof of non-assignability</u> documentation must include written proof that the "non-assignability" is in full compliance of applicable federal law(s). Upon written proof that such "non-assignability" is supported by governing laws, I then <u>instruct</u> the insurer to make out the check to me and mail it directly to the healthcare Provider and address as listed on the claim submitted for benefits. I authorize the check to be deposited as payment and towards the total charges for all healthcare services rendered. I understand that my insurance coverage is a contract between me and my insurance company, health plan or employer group and that I am responsible for all obligations under my plan including providing accurate information and assistance to ensure all benefits entitled under my pan or policy are paid in compliance with plan terms and governing laws. I acknowledge and understand that I may be eligible for any financial hardship, medically indigent or charity care practices program that the provider may have available.

I specifically request and authorize the State Insurance Department or any federal agency having oversight or enforcement authority or responsibilities over my governing Plan, group or health insurer related to entitled benefits and all protected rights, to perform as requested by my authorized representative or business associate as assigned by the above provider, any compliance assistance, administrative reviews or investigations associated with handling of benefits, any appeal requests or other rights not satisfied by my Plan or health insurer. I request any state or federal agency as designated to work directly with my appointed representative as it relates to any request for compliance assistance, administrative review or investigation, wholly in my stead as applicable to all Plan, health insurer and fiduciary obligations. A photocopy of this Assignment shall be considered as effective and valid as the original. I understand this assignment will remain in effect until revoked by me in writing except (a) to the extent that the covered entity has already used or disclosed information under the authorization, or (b) if the authorization was obtained as a condition of obtaining insurance coverage for services rendered, other law that provides the insured or claimant with the right to contest a claim under the policy. I have read and fully understand the agreement.

_____ _____ _____

Signature of Patient/Guarantor | Full Address (Required by Some Insurance Plans) | Date