ASSIGNMENT OF BENEFITS & AUTHORIZATION TO PURSUE APPEAL &/OR LITIGATION OF HEALTH CARE BENEFITS

In consideration of the professional services rendered by **BCT MEDICAL ASSOCIATES** and its affiliated health care providers, ("Health Care Providers"), I, hereby irrevocably direct, authorize, assign and consent to the following:

1. The assignment of my rights to bill, collect, appeal and/or arbitrate my claims for health insurance benefits with regard to the above-captioned claim to Health Care Providers, including but not limited to surgical facility fees, supplies, primary physician, assistant, anesthesia, and any other fees related to my claims, pursuant to my rights under state and/or federal law including but not limited to the federal ERISA statutes, New Jersey Health Claims Authorization, Processing and Payment Act (HCAPPA), and New Jersey Healthcare Quality Act (HCQA).
2. The authorization of Health Care Providers to act as my agent-in-fact with regard to all aspects regarding the above-captioned claim and to receive any and all communications regarding the claim and any appeals or arbitration of the denial of my claim as a substitute beneficiary under my policy of health insurance whether fully funded or self-funded.
3. The authorization of Health Care Providers to initiate, prosecute., and resolve any and all appeals and/or arbitrations and/or legal actions on the denial of my claim, including but not limited to internal appeals with the insurer, outside reviewing entities or agencies as well as arbitrations and litigation matters in state or federal court including but not limited to claims under the federal ERISA statutes, New Jersey Health Claims Authorization, Processing and Payment Act (HCAPPA), and New Jersey Healthcare Quality Act (HCQA).
4. The authorization of Health Care Providers to obtain and/or disclose any Private Health Information as contemplated by HIPAA limited to my claim for insurance benefits and any appeal there from. I have signed a separate HIPAA authorization in this regard.
5. The authorization of Health Care Providers to file a complaint with regard to any denial of my claim(s) with the New Jersey Department of Health and Senior Services, the New Jersey Department of Banking and Insurance, the federal Department of Labor as it relates to ERISA plans, as well as any other governmental agency with jurisdiction over my claim and/or the insurer.
6. The authorization for payment of any and all insurance benefits directly to Health Care Providers to which I might be entitled under the above-captioned claim.

OWNERSHIP

I am aware that my physician may have ownership interest in Edison Surgery Center (ASCs). If you choose to go to another healthcare facility for this procedure, it will have no effect on my relationship with my physician.

OUT OF NETWORK*

I have been informed that BCT MEDICAL ASSOCIATES and some of its affiliates may be an "**Out of Network**" entity. I understand that there is a possibility that partial or total reimbursement for their services may be sent directly to me. When this correspondence from the insurance company arrives, I take responsibility to contact the office within 7 days and provide the following:

1. The **EXPLANATION OF BENEFITS AND ENDORSED CHECK, PERSONAL CHECK OR DEBIT/CREDIT CARD** for the amount of the reimbursement and any corresponding co-insurance, including my deductible.

I understand that if I do not reimburse BCT MEDICAL ASSOCIATES and its affiliates for rendered medical services, I will be sent to collections and additional fees of late charges, interest payments, collection agency fees, attorney fees will apply.

Print Name Patient/Parent: _____

Signature of Patient/Parent: _____

Date: _____