Part 4: Assignment of Insurance Benefits from Medicare and private insurance

Patient's Name _____ MR# _____

ASSIGNMENT OF BENEFITS

I request that payment of authorized benefits be made on my behalf to James C. Wittig, MD for any and all services furnished to the patient listed above by James C. Wittig, MD and/or any of Dr. Wittig's physician assistants or nurse practitioners, and I assign my right to receive these payments to James C. Wittig, MD. I authorize HackensackUMC and Dr. James C. Wittig to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my Health Insurance Plan does not direct payment to Dr. James C Wittig or HackensackUMC, I agree to forward to Dr. James C. Wittig all health insurance payments, which I receive for the services rendered by Dr. James C. Wittig and/or his physician assistants and/or nurse practitioners.

I authorize HackensackUMC or any holder of medical information about me or the patient listed above to release to my Health Insurance Plan such information needed to determine these benefits or the benefits payable for related services.

_____

Parent/Person Legally Responsible Relationship to Patient Date

MEDICARE BENEFITS

I request that payment of authorized Medicare benefits be made on my behalf for services furnished to me by my provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

_____

Parent/Person Legally Responsible Relationship to Patient Date

OTHER HEALTH INSURANCE

I certify that the insurance information that I have provided is accurate, complete and current and that no other coverage or insurance exists.

_____

Parent/Person Legally Responsible Relationship to Patient Date

PATIENT RESPONSIBILITY

I acknowledge that I am responsible for all charges for services provided to the patient listed above which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan. To the extent no coverage exists under my Health Insurance Plan, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by insurance. I further agree that, if permissible by law, I will reimburse HackensackUMC and Dr. James C Wittig for all costs, expenses and attorney's fees that may be incurred by HackensackUMC or Dr. James C. Wittig to collect those charges.

_____

Parent/Person Legally Responsible Relationship to Patient Date