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Assignment of benefits form

MB Orthodontics, Dr. Maryam Bakhtiyari NPI number: 1447470885

_____________________(Print name) with insurance benefits through (insurance name)_________________I hereby authorize benefits to be assigned to the above listed healthcare provider, for healthcare services provided to me by the healthcare provider listed above. I hereby certify that the insurance information that I have provided the above listed healthcare provider is true and accurate as of the date of service and that I am responsible for keeping it updated. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my medical bill is paid in full. I also understand that my insurance company may not pay 100% of the amount of the medical claim, and I may be responsible for any and all amounts not payable by my insurance company, including any portion paid and not applied to a network benefit for any out of network services.

I hear by authorizing the ‘provider’ listed above to submit claims on my behalf to the insurance company, providing benefits and provided to the above listed healthcare provider, in good faith. I fully agree and understand that the submission of a claim does not absolve me of my responsibility to ensure the claim is paid in full.

I hereby irrevocably designate, authorize, and a provider listed above as my true and lawful attorney in fact. This power of attorney is hereby provided for the limited purpose of receiving all payments due under my policy/medical care plan on account of medical services and care rendered or to be rendered. This power of attorney shall automatically terminate without formal action being taken, as soon as the above listed healthcare provider has received payment in full and remedies under applicable regulatory guidelines for all medical care services provided to patients. I hear by confirm and ratify all actions taken by my attorney-in- fact pursuant is the attorney granted herein.

I hereby authorize my insurer to assign and transfer any and all applicable plan, benefits, and rights to provider listed above, and any appointed business associates, working with them for the sole purpose of making sure all protected rights and entitled benefits under my specific plan are administered accurately, including the right to receive any applicable, relevant, plan document/remedies, disclosures, pursue appeals, administrative reviews, and litigation on my behalf. This authorization includes any and all other rights permissible under state and federal laws, as well as entitled plan programs. This is a direct assignment of my rights and benefits under the plan/policy. The payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance said professional service charges over and above this insurance payment. Upon receipt of said check, I authorize the provider listed above to receive any such checks, endorse them for deposit only and to deposit and apply all the proceeds toward payment on my account. This authorization includes any and all rights permissible, including all rights of appeal, disclosures, administrative reviews, litigation on my behalf and remedies under any Title XVIII of the Social Security act, related provisions of Title XI, as well as federal, city or state government programs.

I hear by instruct and direct my insurance company to pay all entitled plan benefits at the stated plan benefit level directly to the provider listed above for all entitled benefits related to services rendered. I understand under applicable ERISA state and/or federal regulatory guidelines that I have the right and authority to direct where payment for services rendered is sent. If my current policy prohibits direct payment to the provider of service, I under my rights per state and federal ERISA regulations hereby, instruct and direct my insurance company to provide SPD documentation, stating such non-assignability clause to myself and provider listed above. Upon proof of non-assigned ability documentation I then instruct that the insurer make out the check to me and mail it directly to the provider insurance policy as payment towards the total charges for the professional services rendered. I agree and understand that any funds received by my insurance company due for services rendered by the healthcare provider listed above, will be immediately signed and sent directly to the provider listed above.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, governmental, agency, or attorney involved in this case. I authorize provider listed above or appointed business associates by the provider to be my personal representative, which allows them as my legally binding authorized representative to (1) submit any and all appeals when my insurance company denies me benefits to which I am entitled, (2) submit any and all requests for benefit information from my insurance company and (3) initiate formal complaints to any state or federal agency that has jurisdiction over my assure and/or benefits. I fully understand and agree that I am responsible for full pavement of the medical debt. If my insurance company has refused to pay 100% of my stated benefits based on build charges, within 90 days of any and all appeals or requests for information. Should the account be referred to an attorney or outside agency for collection, the undersigned shall pay reasonable attorneys fees, and collection expenses. All delinquent accounts bear interest at legal rate. I also agree that any penalties or fines levied against my insurance company will be paid to the provider listed above for acting as my personal representative.

I authorize the above provider to provide medical care reasonable, and at the standard of care as requested by state law.

A photocopy of this assignment shall be considered as effective and valid as the original.

_____________________________ _______________
Signature of Patient/Guarantor Date

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