KINGS ANESTHESIA
PO BOX 347
ORADELL, NJ 07649
TEL: 973-546-3000 FAX: 973-546-4111

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Assignment of Insurance Benefits – Appointment as Legal Authorized Representative I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to the Provider and the providers representatives (hereinafter, "My Authorized Representatives") and I appoint them as my authorized representative with the power to:

- File medical claims with the health plan
- File appeals and grievances with the health plan
- Institute any necessary litigation and/or complaints against my health plan naming me as plaintiff in such lawsuits and actions if necessary (or me as guardian of the patient if the patient is a minor)
- Discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan

I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below 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 bills for professional services from Providers are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

OUT OF NETWORK

I have been informed that Kings Anesthesia is an OUT OF NETWORK entity. I understand there there is a possibility that partial or full reimbursement for their services may be sent directly to me. If correspondence from the insurance company arrives to my mailing address, I take responsibility to contact the office at 862-232-1500 within 7 days. I am responsible for providing the following information: The Explanation of of Benefits, endorsed check, personal check or debit/credit card for the amount of the reimbursement, co-insurance and/ or deductible.

ERISA Authorization

I hereby designate, authorize, and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. I authorize communication with the Provider and his authorized representatives by email..

By signing this form, I also understand that if this provider does not have a contract with my insurance plan, the fees for services will be as they are listed on www.fair health consumer.org. A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

Patient Name _____ Date _____

Patient Signature _____