

ASSIGNMENT OF BENEFITS & AUTHORIZATION
TO PURSUE APPEAL &/OR DENIAL OF BENEFITS

Patient Name _____

Insurer _____

Claim # _____

In consideration of the professional services rendered by Sussex County Total Health, PC, their shareholders, employees, contractors, agents of assigns ("SCTH"), 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 insurance benefits with regard to the above-captioned claim to SCTH, including but not limited to chiropractic fees, physical therapy fees, durable medical equipment fees, supplies, x-ray fees, and any other fees related to my claims.
- 2) The authorization of SCTH 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.
- 3) The authorization of SCTH to initiate and prosecute any and all appeals and/or arbitration or legal actions on the denial of my claim, including but not limited to internal appeals with the insurer, as well as arbitrations.
- 4) The authorization of SCTH 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 SCTH 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, 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 SCTH to which I might be entitled under the above-captioned claim.

PATIENT:

By: _____

Dated: _____

WITNESS:

By: _____

Original on file