Women's Mental Health Specialists℠

LEGAL ASSIGNMENT OF BENEFITS, RELEASE OF PLAN DOCUMENTS & AUTHORIZED REPRESENTATIVE ASSIGNMENT

I hereby irrevocably appoint as my designated authorized representative and assign all entitled Plan benefit payments due under my policy, or health plan for all services rendered, to be sent directly to _____. I authorize my insurer to assign and transfer all applicable benefits, appeal, disclosure, and all other protected rights. remedies and all cause of action due under my plan and wholly in my stead to _____ for all healthcare services rendered and billed by _____ This authorization includes all protected rights applicable under governing federal and state regulations, as well as any regulations under the social security act to _____. I authorize the release of all relevant medical, plan or other claim information necessary to my insurer or governmental agency to pursue a compliant benefit payment, process appeals, administrative reviews, or any litigation required to receive all entitled medical benefits under my health plan or policy.

I hereby convey to the above named provider to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and laboratory in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and lab's expenses.

A photocopy of this Assignment shall be considered as effective and valid as the original. I understand this assignment will remain in effect until revoked by me in writing. I have read and fully understand this agreement.

Name: _____

Signed: ______________________________

Date: ____________________