ASSIGNMENT OF BENEFITS
ERISA AUTHORIZED PERSONAL LEGAL REPRESENTATIVE FORM

Financial Responsibility

I have requested and/or received professional healthcare services from a healthcare provider associated with National Birth Centers Inc. and/or their associates on behalf of myself and/or my dependents. I understand that by making this request, I am responsible for charges incurred during the course of said services. I understand that fees for services rendered are due and payable on the date of service, and agree to pay such charges according to the arrangements that have been made.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to my healthcare provider and/or National Birth Centers, Inc. and associates. I certify that the health insurance information that I have provided to my provider is accurate as of the date set forth below, and that I am responsible for keeping all health insurance information updated. I authorize National Birth Centers, Inc. and/or any affiliates on behalf of me and my healthcare provider to submit claims, on my, and/or my dependent's behalf, to the benefit plan (or administrator) listed on the current insurance card I provide in good faith. I also hereby instruct my benefit plan (or its administrator) to pay directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to National Birth Centers Inc. and/or associates, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and my provider upon request. Upon proof of such non assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to my healthcare provider. I am aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services are paid in full. I understand that I am responsible to pay my deductible and coinsurance.

Authorization to Release Information

I hereby authorize my health care provider to: (1) release any information necessary to my health plan (or its administrator) regarding my 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.

ERISA Authorization

I hereby designate, authorize, and convey to the fullest extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Personal Legal Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf 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 to act on my behalf in 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 my provider and/or National Birth Centers Inc. and/or associates, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines and the ability to bring suit.

A photocopy or electronic transmission of this Assignment/Authorization of Personal Legal Representative shall be as effective and valid as the original.

Insurance Company's Name: ____

Insurance Address: ____

Insurance City, State, Zip: ____

Insurance Payer ID: __________________________________Insurance Phone Number_________________________

Employer Name: ____

Patient's Full Name: ____

Patient's DOB: ____

Member ID: ____

Group Number: ____

Patient's Signature: ____ Date: ________________________

Witness Printed Name: ____

Signature of Witness:____