

ASSIGNMENT OF INSURANCE BENEFITS

If you would like us to process your insurance claims, please provide us with ALL the information requested below and sign beneath the statement.

NAME OF PATIENT _____

POLICY HOLDER'S INFORMATION

NAME OF POLICY HOLDER _____ RELATIONSHIP TO PATIENT _____

SOCIAL SECURITY# _____ DATE OF BIRTH _____

ID# _____ GROUP POLICY NUMBER _____

POLICY HOLDER'S EMPLOYER _____

EMPLOYER'S ADDRESS _____

EMPLOYER'S TELEPHONE NUMBER _____

NAME OF INSURANCE COMPANY _____

ADDRESS WHERE CLAIMS ARE SUBMITTED _____

INSURANCE COMPANY'S TELEPHONE NUMBER - _____

We will file past claims for this condition/injury from the date you were initially seen for the said injury/condition, unless a specified date is indicated. _____

I hereby authorize and request payment to be made directly to Casper Orthopaedic Associates, P.C. for medical treatment provided to myself or any member of my family covered by my medical insurance program. If necessary, I authorize release of medical information relative to any claims submitted to my insurance company. I understand that any part of my bill not paid by my insurance company is my responsibility. Further, should my insurance company not honor this assignment of benefits, I will immediately forward any payment made directly to me by my insurance carrier. This authorization shall remain in effect for twelve (12) months from the date signed. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do, it won't have any affect on any actions they took before they received the revocation. If in the event legal action should become necessary to collect an unpaid balance due for medical services rendered or supplies, I agree to pay reasonable attorney's fees or other such costs as the court determines proper.

SIGNATURE OF PRIMARY POLICY HOLDER _____ DATE _____

Dear Patient:

I invite you to consider allowing us to bill your insurance company. The enclosed form must be completed, signed by the primary insured, and returned to our office. Once this form is received, we will re-file all previous and future charges with your insurance company. A 20% payment will be required for all office charges. However, the remaining balance will not be requested until we have heard from your insurance company in the manner of a payment, denial, or request for additional information. At that time, you may contact our Accounts Manager at (307) 265-7205 or toll free at 1-888-317-2343 to make arrangements.

Thank you for your prompt attention to this matter. If you require any additional information, please do not hesitate to call.

Thank you,

Casper Orthopaedics Associate Billing Department