NJ Advanced Surgical Solutions PC

Val Prokurat, M.D., D.O.

Advanced Minimally Invasive Surgery ♦ General Surgery ♦ Bariatric (Weight Loss) Surgery

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DESIGNATED REPRESENTATIVE FORM

I hereby authorize Provider listed above to submit claims, on my behalf, to the insurance company providing benefits and provided to the above listed healthcare provider, in good faith. I fully agree and understand that the submission of a claim does not absolve me of my responsibility to ensure the claim is paid in full.

I hereby irrevocably designate, authorize and appoint Provider listed above as my true and lawful attorney-in-fact. This power of attorney is hereby provided for the limited purpose of receiving all payments due under my policy/medical care plan on account of medical services and care rendered or to be rendered. This power of attorney shall automatically terminate, without formal action being taken, as soon as the above listed healthcare provider has received payment in full and remedies under applicable regulatory guidelines for all medical care services provided to patient. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein.

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby instruct and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue all payment check(s) and correspondence directly to Dr. Val Prokurat with NJ Advanced Surgical Solutions for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance. I understand under applicable ERISA, state and/or federal regulatory guidelines that I have the right and authority to direct where payment for services rendered is sent. If my current policy prohibits direct payment to the provider of service, I under my rights per state and federal ERSIA regulations hereby instruct and direct my Insurance Company to provide SPD documentation stating such non-assign ability clause to myself and Provider listed above. I authorize the release of any information pertinent to my case to any insurance company, adjuster, governmental agency or attorney involved in this case. I authorize Provider listed above or appointed business associates by the provider to be my personal representative, which allows them as my legally binding authorized representative to: (1) submit all appeals when my insurance company denies me benefits to which I am entitled, (2) submit all requests for benefit information from my insurance company, and (3) initiate formal complaints to any State or Federal agency that has jurisdiction over my insurer and/or benefits. I fully understand and agree that I am responsible for full payment of the medical debt if my insurance company has refused to pay 100% of my stated plan benefits based on billed charges, within ninety (90) days of all appeals or request for information. Should the account be referred to an attorney or outside agency for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. All delinquent accounts bear interest at the legal rate. I also agree that any penalties or fines levied against my insurance company will be paid to Provider listed above for acting as my personal representative.

I authorize the above provider to provide medical care reasonable and at the standard of care as required by state law.

A photocopy of this Assignment shall be considered as effective and valid as the original.

_____
Name of Patient/Guarantor

_____
Signature of Patient/Guarantor Date