First State Pediatrics
Hockessin

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Assignment of Benefits, Release of Information, and Statement of Assistance

By completing this form, you will help ensure that First State Pediatrics, LLC, and its physicians are paid by your health insurance policy or benefit plan.

ASSIGNMENT OF BENEFITS

I request and permit my insurance company or benefit plan to pay directly to First State Pediatrics, LLC, money due for health care services, supplies and equipment under the terms of my insurance policy or benefit plan. I understand that I may be responsible for payment in full of any amount due that is not covered or paid for by my insurance policy or benefit plan.

RELEASE OF INFORMATION AND STATEMENT OF ASSISTANCE

- I permit First State Pediatrics, LLC, to provide my insurance company or benefit plan with any information necessary for First State Pediatrics to receive payment for services, supplies, and equipment.
- I permit First State Pediatrics, LLC, and/or its attorneys to request, on my behalf, any information related to my health insurance policy or benefit plan (including, but not limited to, proof of my insurance or benefit plan). This information may be given directly to First State Pediatrics or its attorneys.
- I permit First State Pediatrics, LLC, and/or its attorneys, to file, on behalf of themselves and on my own behalf, claims for benefits and/or appeals of any denied claims.
- I agree to assist First State Pediatrics in collecting benefits that may be due or payable under my insurance policy or benefit plan for the services, supplies, and equipment provided.
- I agree to provide any additional information needed to process the claim for payment.
- I agree that First State Pediatrics, LLC< may take action in my name against my insurance company or benefit plan to receive any benefits that may be due or payable under the insurance policy or benefit plan.

A photocopy or other reproduction of this statement shall be considered as valid as the original.

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Signature Date

_____

Print Name of Person Responsible for Patient

_____

Patient Name DOB