Assignment of Benefits Form

Norwich Medical Associates
12 Case Street, Suite 103
Norwich, Connecticut 06360
860-889-0147

Date: _____
Patient Name: _____
Insurance ID#: _____
Group #_____

I, _____, understand that services rendered to me by Norwich Medical Associates are my financial responsibility and that the provider will bill my insurance company listed above, as a courtesy. I authorize my insurance company to pay my benefits directly to my insurance company listed above and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECET ASSIGMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance plan.

I have been given the opportunity to pay my copay and/coinsurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state and federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my insurance company.

I authorize the provider to release any information necessary to adjudicate the claim.

I also understand that should my insurance company send payment to me, I will forward the payment within 48 hours. I agree that if I fail to send payment to the provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve monies.

I understand if I fail to pay copays, coinsurance or deductible amounts and the practice is forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve monies.

I am aware that if I experience a change in my insurance it is my responsibility to notify the practice immediately. I understand if claims are denied due to incorrect insurance information payment of these claims could become my responsibility and I will be responsible for any cost incurred by the office to retrieve monies.

Dated: _____ Witness: _____

_____ _____

Signature of policyholder Patient, Guardian or Legal Representative