

GBMC HealthCare
6701 North Charles Street
Baltimore, MD 21204

Patient Name: _____

Date of Birth: _____

ASSIGNMENTS OF INSURANCE BENEFITS AND THIRD PARTY CLAIMS – I hereby authorize payment directly to GBMC Healthcare of hospital benefits otherwise payable to me, including major medical insurance benefits, PIP benefits, sick benefits, or injury benefits due because of any insurance policy and the proceeds of all claims resulting from the liability of the third party payable by any person, employer, or insurance company to or for the patient unless the account is paid in full upon discharge. I also authorize payment of surgical or medical, including major medical benefits, directly to attending physicians, but not to exceed charges for these services. I understand that I am financially responsible to the hospital and physicians for charges, whether or not covered by this assignment. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney’s fees and collection expense. All delinquent accounts may bear interest at the legal rate. I further authorize refund of overpaid insurance benefits in accordance with my policy conditions where my coverages are subject to coordination of benefits clause. I understand that I am responsible for any deductibles, coinsurance, or co-payments associated with my policy to include Point of Service (POS), Preferred Provider Organization (PPO), “opt-out” plan, “out-of-network” preferred, and indemnity benefits and for payment of services not covered under my policy or those services I elect to receive if denied for coverage by my insurer. I will contact my insurer or Health Advocacy Unit of the Attorney General’s Office to learn how to appeal adverse decisions made by my insurer.

MEDICARE/MEDICAID PATIENT CERTIFICATION – I certify that the information given by me in applying for payment under TITLE XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf.

PERMISSIONS / ACKNOWLEDGEMENTS

USE AND DISCLOSURE OF HEALTH INFORMATION – I authorize GBMC Healthcare and independent physicians or other practitioners providing services by or in the Health System to disclose any health information (including information related to psychiatry, drug abuse, alcoholism, or HIV testing) for my treatment as well as use of routine Health System operations and payment for services and associate care. I further authorize release of health information to other health care providers for continuing care and treatment.

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PRE-CERTIFICATION REQUIREMENTS – If my insurance company or third-party requires pre-certification, then I understand that it is my responsibility to contact them to obtain such certification. EXCEPTION: Medicare

AUTHORIZATION FOR TREATMENT- I authorize _____ to provide medical treatment to the patient named on this form.

Has the patient received the Notice of Privacy Practices?

_____ Yes

_____ No

Reason no NOPP given:

_____ Newborn

_____ Patient Unable to Accept

I have read and understand in its entirety the information provided on this document.

Signature of Patient or Patient

Representative: _____ **Date:** _____

Signature of Patient or Patient

Representative: _____ **Date:** _____

Signature of Patient or Patient

Representative: _____ **Date:** _____

Signature of Patient or Patient

Representative: _____ **Date:** _____

Signature of Patient or Patient

Representative: _____ **Date:** _____

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Representative: _____ **Date:** _____

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Representative: _____ **Date:** _____

Assignment of Benefits form physician practices