PENNSYLVANIA NEPHROLOGY ASSOCIATES, PC
SECTION ON RENAL DISEASES AND HYPERTENSION
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ASSIGNMENT OF BENEFITS

I, ____, request the payment of authorized insurance benefits to be made on my behalf to Pennsylvania Nephrology Associates, P.C. (PNA). I authorize PNA to release to my insurance company(s) and its agents any information needed to determine these benefits.

I understand my signature requests that payment be made and authorizes the release of medical information necessary to pay the claims. My signature authorizes the release of information to my insurance company (s) or its agents.

Check all that apply:

( ) Medicare: PNA agrees to accept the approved reimbursement determination of the Center for Medicare and Medicaid Services (CMS) or its agents as the full charge. The patient is responsible for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of CMS or its agents.

( ) Medicare Supplement: Name of Carrier:________________________________

( ) Insurance: Name of Carrier:____
The patient is responsible for all deductibles, coinsurance and non-covered services; including out of network services. It is the **patient's responsibility to secure all referrals and pre-approvals for services as outlined in the patient's insurance policy guidelines.** Insurance coverage is a contract between the patient and the insurance company.

Patient Signature________________________________Date__________________