Pediatric Specialists of Virginia

Children's National. INOVA

AUTHORIZATION FOR CLAIMS, PAYMENTS AND REVIEWS

For Medicare Recipients: I certify that the information provided to me in applying for payment under Title XVIII of the social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to PSV for any services furnished to me during the applicable periods of medical care.

Assignment and Coordination of Insurance Benefits: I agree to provide information regarding all health insurance benefits to which I/the patient may be entitled. I hereby assign payment(s), if any, from insurance carrier(s) health benefit plan to PSV for services rendered to the patient. I hereby authorize payments directly to Pediatric Specialists of Virginia (PSV), including any benefits otherwise payable to me under the terms of my policy, but not to exceed the balance due to PSV for services rendered to me during the applicable period(s) of medical care.

Unauthorized, Non-Covered, or Out-of-Plan Services: I understand that if my insurance carrier or administrator of benefits does not consider any service rendered a covered service or has not authorized these services, they will not pay; and I agree to pay for these services. I also understand and acknowledge that in the case where PSV is deemed out-of-plan/network, there may be reduced benefits; and I may be required to pay a higher co-pay, deductible or co-insurance amount.

Authorization to Release Information: I hereby authorize PSV to release any information acquired during the course of treatment necessary to process insurance claims and/or follow up for healthcare operations and securing payment for services rendered.

Responsibility for Payment: In my capacity as patient, legal representative or representative payee for the patient, I agree to pay all charges for which I may be legally responsible including, but not limited to, health benefit deductibles, copayments, co-insurance and non-covered services. In the event my account must be placed with an attorney or collection agency to obtain payment, I agree to pay reasonable attorneys' fees and other collection costs.

Automobile Accident Patients: Notice regarding the assignment of medical expense benefits may be provided to you by your Auto Insurance Company.

By signing below, I certify I have:

- Read and understand the foregoing;
- Had the opportunity to ask questions and have them answered;
- Accepted the above conditions and terms; and
- Read the notice, if applicable, regarding assignment of medical expense benefits for automobile accident patients.

I, therefore, agree:

- To pay all charges for which I may be legally responsible including, but not limited to, health insurance deductibles, co-payments, and non-covered;
- To pay the reasonable attorneys' fees and other collection costs incurred by PSV in the event my account must be placed with an attorney or collection agency to obtain payment; and
- And understand that this document will remain in effect for my present visit and any future outpatient or physician office visits to PSV, unless specifically rescinded by me in writing.

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Signature of Patient, Parent, Guardian or Personal Representative   Date

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Printed Name of Patient, Parent, Guardian or Personal Representative

Notice: It is not required to sign this Authorization for Claims, Payments and Reviews Form. If this Form is not signed, all charges will be billed to you directly instead of to your insurance plan.

Patient Identification

If label is not available, please complete:

Patient Name ______________________________

DOB: ____________ MR# ________________