INOVA

1PMTREV

Patient Name: _____ Medical Record #: _____

Date of Service: _____ Location: _____ Account #: _____

Authorization for Claims Payment and Reviews - Ambulatory

1. 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 Inova (or its affiliates) for any services furnished to me during the applicable periods of medical care.

2. 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 Inova (or its affiliates) for services rendered to the patient. I hereby authorize payments directly to Inova, including any benefits otherwise payable to me under the terms of my policy, but not to exceed the balance due to the Inova (or its affiliates) for services rendered to me during the applicable periods of medical care.

3. 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 of 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.

4. 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.

5. Automobile Accident Patients - Notice regarding the assignment of medical expense benefits will be provided to you in a separate document.

By signing below, I certify I have read and understand the foregoing; have had the opportunity to ask questions and have them answered and accept the above conditions and terms; **have read the notice regarding assignment of medical expense benefits for automobile accident patients, if applicable;** and I 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. I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by Inova. I understand and agree this document will remain in effect for my present visit and any future outpatient or physician office visits to Inova, unless specifically rescinded in writing by me.

_____ _____
PATIENT (GUARDIAN, ETC.) DATE / TIME

_____
RELATIONSHIP TO PATIENT (IF NOT SIGNED BY PATIENT)

_____ _____
WITNESS DATE / TIME

Notice: patients are not required to execute this assignment of benefits form. If you do not execute this form, 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: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

INOVA HEALTH SYSTEM

AUTHORIZATION FOR CLAIMS, PAYMENT, AND REVIEWS - AMBULATORY

White: Medical Records • *Yellow:* Patient Copy

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