Please fill out this form if you are utilizing insurance

New Jersey Department of Banking and Insurance

CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary.* This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY, does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS

I, [ ], by marking [√] (or [x]) and signing below, agree to:

☐ representation by [ ] in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.

☐ release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: _____ Ins. ID#: _____ Date: _____

Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative (provide contact information on back)

* If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

Date: _____

Dear Insurance Carrier,

I understand you may be holding up payment of my claims because you are waiting to update your records regarding my status and my coverage. The following is my updated information:

Name of patient _____ SS# _____ DOB _____

Insured Information:
Insured Name _____ Policy ID# _____ Relation to Insured _____

PLEASE CHOOSE SECTION THAT APPLIES & CHECK ONLY 1 LINE

Spouse / Partner:

_____ I am the patient AND the insured AND I have no other insurance coverage.

_____ I am the patient, BUT the insured is my spouse/partner _____. I am not employed and therefore have no other insurance coverage of my own.

_____ I am the patient, BUT the insured is my spouse/partner _____. I am employed at _____ but have no coverage through that employer.

_____ I am the patient & have my own coverage – the following is my coverage information:
Primary Ins_____ Insured Name_____ Insured DOB_____
Secondary Ins_____ Insured Name_____ Insured DOB_____

_____ _____
Signature Date

Dependent Child Over 18: (covered under parent's policy)

_____ I am a FT student & have 1 policy. Attached is my current school schedule.
Primary Ins _____ Insured Name_____ Insured DOB_____

_____ I am a FT student & have 2 policies. Attached is my current school schedule.
Primary Ins_____ Insured Name_____ Insured DOB_____
Secondary Ins_____ Insured Name_____ Insured DOB_____
**determining primary/secondary is usually based on the 'birthday rule'.

_____ _____
Signature Date

Dependent Child Under 18: (covered under parent's policy)

_____ I am a minor dependent and only covered under one policy:
Primary Ins _____ Insured Name_____ Insured DOB_____

_____ I am a minor dependent and covered under two policies:
Primary Ins_____ Insured Name_____ Insured DOB_____
Secondary Ins_____ Insured Name_____ Insured DOB_____
**determining primary/secondary is usually based on the 'birthday rule'.

_____ _____
Parent or Guardian Signature Date

ASSIGNMENTOF BENEFITS / ERISA AUTHORIZATION FORM
Eastpointe Integrated Healthcare / CB&C / L. Contreni

Financial Responsibility

I have requested professional services from Eastpointe Integrated Healthcare on behalf of myself and/or my dependents, and understand that by making this request; I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Eastpointe Integrated Healthcare / CB&C, Inc. I certify that the health insurance information that I provided to Eastpointe Integrated Healthcare is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Eastpointe Integrated Healthcare / CB&C / L.Contreni to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Eastpointe Integrated Healthcare, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Eastpointe Integrated Healthcare directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Eastpointe Integrated Healthcare, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Eastpointe Integrated Healthcare / CB&C / L.Contreni upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Eastpointe Integrated Healthcare.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Eastpointe Integrated Healthcare are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Eastpointe Integrated Healthcare / CB&C / L.Contreni to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Eastpointe Integrated Healthcare / CB&C / L.Contreni to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Eastpointe Integrated Healthcare and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____ _____

Print Name Date

_____ _____

Signature Date

Date: _____

Dear Insurance Carrier:

I, _____, am currently receiving care at Eastpointe Integrated Healthcare. Please know that this care is *not related* to any auto accident, workers' compensation injury or any other type of injury, which would render a third party liable for these bills.

I trust this statement will clarify this matter and there should be no delay in processing any claims submitted to you by this facility. If you have any questions, do not hesitate to contact me personally.

_____
Print Name

_____ _____
Signature Date