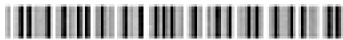
The Children's Hospital of Philadelphia



ADM-1286
Rev. 06/04

NAME SEX M F

MR#

AGE / DATE OF BIRTH

ACCOUNT#

(PATIENT PLATE IMPRINT)

ASSIGNMENT OF BENEFITS, RELEASE OF INFORMATION AND STATEMENT OF ASSISTANCE

By completing this form, you will help ensure that The Children's Hospital of Philadelphia and its physicians are paid by your health insurance policy or benefit plan.

ASSIGNMENT OF BENEFITS

I request and permit my insurance company or benefit plan to pay directly to The Children's Hospital of Philadelphia or any of its affiliates (CHOP) money due for healthcare services, supplies and equipment (including hospital and physician services) under the terms of my insurance policy or benefit plan. Affiliates of The Children's Hospital of Philadelphia include, but are not limited to, the following:

- The Children's Hospital of Philadelphia
- The Children's Seashore House of The Children's Hospital of Philadelphia
- The Children's Hospital of Philadelphia Practice Association
- The Children's Hospital of Philadelphia Home Care
- CHOP Clinical Associates
- Children's Anesthesiology Associates
- Children's Anesthesiology Associates of New Jersey
- Children's Health Care Associates
- Children's Health Care Associates of New Jersey
- Children's Surgical Associates
- Children's Surgical Associates of New Jersey
- Radiology Associates of Children's Hospital

I understand that I may be responsible for payment in full of any amount due that is not covered or paid for by my insurance policy or benefit plan.

RELEASE OF INFORMATION AND STATEMENT OF ASSISTANCE

- I permit CHOP to provide my insurance company or benefit plan with any information necessary for CHOP to receive payment for services, supplies and equipment.
- I permit CHOP and/or its attorneys to request, on my behalf, any information related to my health insurance policy or benefit plan (including, but not limited to, proof of my insurance or benefit plan). This information may be given directly to CHOP and/or its attorneys.
- I permit CHOP and/or its attorneys, to file, on behalf of themselves and on my own behalf, claims for benefits and or appeals of any denied claims.
- I agree to assist CHOP in collecting benefits that may be due or payable under my insurance policy or benefit plan for the services, supplies and equipment provided.
- I agree to provide any additional information needed to process the claim for payment.
- I agree that CHOP may take action in my name against my insurance company or benefit plan to receive any benefits that may be due or payable under the insurance policy or benefit plan.

A photocopy, or other reproduction of this statement shall be considered valid as the original.

Printed Name of Patient/Parent/Legal Guardian **Relationship to patient**

Signature of Patient/Parent/Legal Guardian **Date**