Assignment of Benefits Form

Dr. Marvin D. Goldenstein, DDS
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Phoenix, AZ. 85032
602-971-7181/F-602-992-8897

Date: _____
Patient: _____
ID #: _____
Group #: _____

I, _____, understand that services rendered to me by Dr. Marvin Goldenstein, DDS are my financial responsibility and that the provider will bill my insurance company _____(insurance company name) as a courtesy. I authorize my insurance company to pay my benefits directly to Dr. Goldenstein and I understand that I will be fully responsible for any outstanding balance on my account. THIS HAS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above –mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state and federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by _____.(insurance company)

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to Dr. Goldenstein within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with collections process; I will be responsible for any costs incurred by the office to retrieve the monies. In the event patient receives any check, draft or other payment subject to this agreement, I will immediately deliver said check, draft or payment to the Provider.

I authorize the provider to initiate a complaint or file an appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Date: _____ Witness: _____

Sign: _____ _____
(Signature of policy holder) (Patient or Guardian)