**ASSIGNMENT OF BENEFITS, AUTHORIZATION TO SETTLE CLAIM AND DIRECTION TO PAY MEDICAL PROVIDER DIRECTLY**

By my signature below, for good and valuable consideration (including but not limited to the extension of credit to me), I hereby assign, transfer and convey to _____ (hereinafter "the Provider") all of my rights, title and interest in and to medical expense reimbursement in whatever form, including but not limited to any PIP coverage, Medical Payments coverage or other health benefits indemnification and/or agreement otherwise payable to me. This payment shall not exceed my indebtedness to the Provider and I acknowledge that I will timely pay any indebtedness owed by me to the Provider that is not otherwise satisfied by the above-mentioned assigned proceeds. I also acknowledge that any medical expenses not covered under my insurance policy will be my responsibility.

I further authorize the Provider to negotiate, collect and settle any claim with any insurance carrier or other third party payor with regard to these services, which authorization shall include authority to:
(1) request and receive from any insurer or any other party any and all documentation and records that I am empowered to request regarding this claim, including, without limitation, a statement of coverage, policy declarations page, insurance policy, IME Reports, notices sent to me regarding appointments for Independent Medical Examinations and Examinations Under Oath (including proof of mail), EUO Transcripts, Peer Review Reports, coverage denial letters, Explanations of Benefits, and PIP Payout Logs, without regard as to whether such documentation has already been provided to me and,
(2) to endorse in my name on any check issued for payment where benefits were assigned.
By way of this assignment and notice, I further instruct you, the insurer, to furnish to Provider copies of all future notices affecting Provider's interest in this claim, including, without limitation, any notices of requested medical examinations or statements.

The Provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit *shall not* be deemed a waiver, *accord, satisfaction*, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. If there is a dispute regarding whether bills are reasonable, related, necessary, or fraudulent, I hereby instruct my insurer to set aside and not disburse funds until the issue is resolved. I instruct my insurer to notify the Provider immediately of any such dispute with specificity in writing what the issues are.

I further direct my insurer to direct all payments for services rendered by the Provider directly to Provider at the billing address contained on Provider's medical bills.

THIS IS A DIRECT AND IRREVOCABLE ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY OF INSURANCE.

I have read the foregoing and understand and agree to each of the above provisions:

_____ _____

Patient's signature Date