PATIENT ASSIGNMENT OF BENEFIT & CONSENT FORM

NAME OF PROVIDER: _____

PRACTITIONER NAME: _____

Patient Name		Date of Birth
		mm/dd/yyyy
Member's Name	Policy #	Certificate #
	165578	

☐ I hereby assign my benefits payable from the services received by the above named registered and/or licensed health care provider/practitioner and authorize payment directly to him/her.

☐ I agree to have this assignment authorization to be valid from the date of signature, unless otherwise revoked by me in writing. I agree that a photocopy or electronic version shall be as valid as the original.

I authorize the above named provider to submit and disclose personal information concerning any claim submitted on my behalf with NB Pipe Trades and/or NexgenRX only when the information is necessary to adjudicate this benefit claim. Information may be used for purposes of payment, accuracy and audit.

Signature of Member/Patient: _____ Date: _____

Please Print Name of Member/Patient: _____

Note to Providers/Practitioners: A copy of this authorization to assign benefits through theclaimsxchange.com must be filed in the patient file in the event of an audit.