

## **ASSIGNMENT OF BENEFITS**

This Assignment of Benefits allows Pediatrix Medical Group to be paid directly by my health insurance carrier for medical services rendered by its providers. By signing this I assign and transfer to Pediatric Medical Group all rights, title and interest in all benefits payable for the services rendered, which are provided in any and all insurance policies and health benefit plans from which my dependents or I are entitled to recover. I hereby designate Pediatrix Medical Group to act as my representative during insurance or plan benefits appeal in the event of a coverage limitation or denial. I understand that Pediatrix Medical Group has the right to decline or accept this designation at the time a limitation or denial is received. The outcome of any appeal is not guaranteed and I understand that I may be responsible for any charges that remain unpaid by the insurance or benefit plan regardless of the outcome of any appeal. I have read this assignment of benefits, and I have signed this document freely and without inducement.

Insurance Policy Holder Name \_\_\_\_\_

Insurance Policy Holder Signature \_\_\_\_\_

Signature Date \_\_\_\_\_