Gwinnett Hospital System

PLACE LABEL HERE

GUARANTEE OF PAYMENT/ ASSIGNMENT OF BENEFITS/ AUTHORIZATION TO PROCESS CLAIMS
Center For Cancer Care

GUARANTEE OF PAYMENT/ASSIGNMENT OF BENEFITS:
In consideration of the Hospital's advancing credit to me for my hospital care and services, I hereby irrevocably assign and transfer to Gwinnett Hospital System and treating Physicians all benefits and payments now due and payable or to become due and payable to me under any insurance policy or policies, under any replacement policies thereof, under any self-insurance program, under any third-party actions against any other person or entity, or under any other benefit plan or program (hereafter referred to as Benefits) for this or any other period of hospitalization and related outpatient care.

I understand and acknowledge that this assignment does not relieve me of my financial responsibility for all hospital charges and treating Physician charges incurred by me or anyone on my behalf, and I hereby accept such responsibility, including but not limited to payment of those fees and charges not directly reimbursed to the Hospital and treating Physicians by any Benefit plan or program. Furthermore, I agree to pay all costs of collection, reasonable attorneys' fees and court costs incurred in enforcing this payment obligation.

AUTHORIZATION TO PROCESS CLAIMS & RELEASE OF INFORMATION:
I authorize Gwinnett Hospital System and the independent contractor physicians and/or professional corporations that render services to me to process claims for payment by my insurance carrier on my behalf for covered services provided to me at Gwinnett Hospital System. I authorize the release of necessary information, including medical information, regarding medical services rendered during this admission or any related services or claim, to my insurance carrier(s), including any managed care plan or other payor, past and/or present employer(s), Medicare, CHAMPUS/TRICARE, authorized private review entities and/or utilization review entities acting on behalf of such insurance carrier(s), payers, managed care plans and/or employer(s), the billing agents and collection agents or attorneys of Gwinnett Hospital System and/or the independent contractor physicians and/or professional corporations, my employer's Worker's Compensation carrier, and, as applicable, the Social Security Administration, the Health Care Financing Administration, the Peer Review Organization acting on behalf of the federal government, and/or any other federal or state agency for the purposes(s) of satisfying charges billed and/or facilitating utilization review and/or otherwise complying with the obligations of state or federal law. Authorization is hereby granted to release health record data and/or copies to my attending and/or admitting healthcare professional and/or any consulting healthcare professional and/or any healthcare professional I may be referred to for follow-up care. I further authorize Gwinnett Hospital System and any other healthcare provider or professional rendering services to me to obtain from any source medical history, examinations, diagnoses, treatments and other health or insurance authorization information for the purpose(s) of satisfying charges billed and/or facilitating utilization review, providing medical treatment and/or the evaluation of such treatment, and/or otherwise complying with the obligations of state or federal law. A photocopy of this Authorization may be honored.

MEDICARE PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST:
I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a RELATED Medicare claim. I request that payment of authorized benefits be made on my behalf.

I understand my signature covers visits to the CENTER FOR CANCER CARE for 365 days from the date I sign this form.

SIGNED: _____ _____ _____
Patient/Patient's Representative | Relationship if other than self | Date

WITNESS: _____

Reason If Unable to Sign: _____