MIDWIVES OF NEW JERSEY
Serving Women, Honoring Birth.

OUT OF NETWORK CONSENT FORM

Patient Name: _____

Insurance Company:_____

Policy #:_____ Group #: _____

I hereby instruct and direct my insurance company to pay the professional or medical benefits directly to *The Midwives of New Jersey, LLC* as payment toward the total charges for the professional services rendered.

If my current policy prohibits direct payment to *The Midwives of New Jersey, LLC*, I instruct and direct my insurance company to pay the professional or medical benefits to myself and mail as follows:

The Midwives of New Jersey, LLC
PO Box 253
Mount Olive, NJ 07828

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

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize *The Midwives of New Jersey LLC,* to initiate a complaint, reopening, appeal or Fair Hearing on my behalf to the insurance company for adjudication as necessary to acquire full payment of the services represented on the claim.

_____ _____
Patient/Policy Holder Signature Date

_____ _____
Witness Signature Date