**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:

## ***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.**

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Patient/Policy Holder Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature Date