



**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.