At the Pyramid Center, 530 Lakehurst Road, Suite 101, Toms River, NJ 08755
Raritan Bay Medical Pavilion, 2 Hospital Plaza, Suite 310, Old Bridge, NJ 08857

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## Legal Assignment of Benefits & Designation of Authorized Representatives

I, the undersigned, represent that I have valid and in-force insurance and/or employee health care benefits coverage, and hereby assign and convey the right of payment directly to **Ocean Orthopedic Associates (the "provider(s)"), its affiliates and their affiliated law firms** as my Statutory Derivative Beneficiary (SDB), commonly known as a Designated Authorized Representative, and a Claimant under the "Patient Protection and Affordable Care Act" (PPACA), existing ERISA and other applicable federal and state laws, of all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from the provider(s), regardless of the provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to the provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from the provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. The provider(s) and its affiliates are assigned the right to payment and the right to receive payment.

I hereby convey to the provider(s), to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, cause of action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable result of the medical services I received from the provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but not limited to, (1) obtaining information about the claim to the same extent as the assignor, including, but not limited to, issuance of reimbursement checks, Explanation of Benefits and any/all correspondence related to claims reimbursement directly to the provider; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; (5) any and all administrative and judicial actions by the provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, to bring suit by the provider(s) against such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Provider(s) has the right to pursue all causes of action, filing suit, inclusive of all necessary steps on ERISA or others claims. This assignment confers assignation for other claims, including breach of fiduciary duty and civil penalties. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

________________________________ ________________________
Signature of Insured/Guardian/ Plan Beneficiary    Date

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Print Name of Insured/Guardian/ Plan Beneficiary    Account Number