WellCare Chronic Care Management

WellCare, TCCM 90 Main Street/250 Moore Street Hackensack, NJ 07601

Assignment of Benefits

Financial Responsibility

All Professional and medical services rendered are charged to the patient and are due at time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I Hereby authorize and direct my insurance carriers, including Medicare, private insurance and any other health medical plan, to issue payment check(s) directly to WellCare. TCCM for services rendered to myself and/or my dependents regardless of my insurance benefits of any period.

Authorization to Release Information

I hereby authorize WellCare, TCCM: (1) release any information necessary to insurance carriers regarding my illness and treatment, (2) process insurance claims generated in the course of examination if treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

I have requested medical services from WellCare, TCCM on behalf of myself and/or my dependents, and understand by making this request my insurance company will be billed for services rendered for any or all charges incurred of the services authorized.

I hereby authorize WellCare, TCCM to release any necessary information to my school and/or employer, regarding myself and/or my dependents; information released pertains only to Covid-19 results. This is in compliance with state and federal mandates.

I further understand that fees are due and payable on the date that the services are rendered and agree to provide all medical insurance information in order to process claims for reimbursement. There is no co-pay or balance billing for Covid-19 testing. A photocopy of this assignment is to be considered as valid as the original.

_____

Patient/Responsible Party Signature

_____

Parent/Guardian Signature

_____

Witness

Date: _____

Complete if no insurance

Without ID: I do hereby attest that I do not hold a state ID, Driver's License, or SSN and do not have active insurance coverage at this time, individually or through my employer or any state/federal program, to the best of my knowledge. Leave SSN/ID# blank below.

With ID: I do hereby attest that I do not hold an active insurance plan, individually or through my employer/state/federal program to the best of my knowledge.

SSN/ID#:_____

Signature_____