

BEACON HEALTHCARE ASSOCIATES

41 Oakland Road, Suite 100
Asheville, NC 28801

David A. Clements, MD, PLLC
Sarah C. Davis, PA-C
Martha K. Hoffmann, PA-C

PATIENT REASSIGNMENT OF BENEFITS FORM

Please read and sign the following

INSURANCE PATIENTS: Beacon Healthcare Associates (David A. Clements, MD, PLLC), provider, will file your claim to your primary, secondary, tertiary (and supplemental) carrier(s), with the information you have provided on the Patient Information Form. You will be responsible for your yearly deductible, copay, co-insurance and other fees not covered by your insurance. If, after 45 days, your claim is not paid, or if you do not have an insurance coverage policy, you will be responsible for the remaining balance.

▪ **SIGNATURE:** _____ **Date** _____

REASSIGNMENT OF BENEFITS: I authorize Beacon Healthcare Associates (David A. Clements, MD, PLLC) to release any information, originals or copies, needed to pay and/or process a claim that may be filed on my behalf. I hereby authorize payment to Beacon Healthcare Associates (David A. Clements, MD, PLLC) benefits specified and otherwise payable to me for any services rendered subsequent to this date and for such other charges as may be made by this office. I agree to pay for charges not covered or denied by my insurance.

▪ **SIGNATURE:** _____ **Date** _____

AUTHORIZATION/PRE-CERTIFICATION:

Does your insurance require? Yes No

If yes, authorization or pre-certification # _____