New York State Out-of-Network Emergency and Surprise Medical Bill Assignment of Benefits Form

Use this form if you get a surprise medical bill or a bill for out-of-network emergency services and want the services to be treated as in-network. This form is used to protect consumers from certain surprise bills for health care services and out-of-network emergency charges, including inpatient services following an emergency room visit. **Please note:** This form is NOT required for out-of-network emergency services, but provides protection from bills for such services.

To use this form, complete and sign it. A copy must be sent to your health care provider and your insurer (include a copy of any bill you received for these services).

Use this form when:

- You received a bill for services from a non-participating physician at a participating hospital or ambulatory surgical center, where a participating physician was not available; a non-participating physician provided services without your knowledge; or unforeseen medical circumstances happened when the services were provided. You did not choose to receive services from a non-participating physician instead of from an available participating physician.
- You received a bill for services for which you were referred by a participating physician to a non-participating provider, but you did not sign a written consent that you knew the services would be out-of-network and result in costs not covered by your insurer. A referral occurs: (1) during a visit with your participating physician, a non-participating provider treats you; or (2) your participating physician takes a specimen from you in the office and sends it to a non-participating laboratory or pathologist; or (3) for any other health care services when referrals are required under your plan.
- You received emergency services from an out-of-network hospital or doctor, including inpatient services following an emergency room visit.

I assign my rights to payment to my provider and I certify to the best of my knowledge that:
I (or my dependent) received emergency services, inpatient services following an emergency room visit, or a surprise bill from a provider. I want the provider to seek payment for this bill from my insurance company (this is an "assignment"). I want my insurer to pay the provider for any health care services I or my dependent received that are covered under my health insurance. With my assignment, the provider cannot seek payment from me, except for any in-network copayment, coinsurance or deductible that I owe. If my insurer paid me for the services, I agree to send the payment to the provider.

Patient Name:	**Date of Service:**
Patient Mailing Address:	**Patient City/State/ZIP:**
Insurer Name:	**Insurance ID No**:
Provider Name: Epilepsy and Neurophysiology Medical Consulting PC	**Provider Phone Number:** 914 428 3651
Provider Mailing Address: 333 Westchester Ave, White Plains New York	**Provider City/State/ZIP:** 10604

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

_____ (Signature of patient)

_____ (Date of signature)

If you have questions regarding this form contact the Department of Financial Services at 1-800-342-3736.
NYS FORM OON-AOB (7/22/20)