Boas Family Chiropractic
Dr. Kara A. Boas
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AUTHORIZATION & ASSIGNMENT OF RIGHTS

TO PURSUE APPEAL OF DENIAL OF HEALTH CARE BENEFITS

In consideration of the professional chiropractic services rendered by Boas Family Chiropractic,

I _____ hereby irrevocably direct, authorize and consent to the following:

1. The assignment of my rights to appeal the denial of health care insurance benefits regarding the above-captioned claim to Health Care Provider, including but not limited to all rights and authority I may have pertinent to the **Health Care Quality Act N.I.S.A.** 26:25-1 et.seq. and its implementing regulations codified at Title 8, Chapter 28 of New Jersey Administration Code.
2. The authorization of Health Care Provider to act as my agent-in-fact with regard to all aspects regarding the above -captioned claim and to receive any and all communications regarding the claim and any appeals of the denial of my claim.
3. The authorization of Health Care Provider to initiate and prosecute any and all appeals of the denial of my claim, including but not limited to first and second level internal appeals with my insurer as well as external appeals under the Independent Health Care Appeals Program administered by the NJ Department of Health and Senior Services.
4, The authorization of Health Care Provider to obtain and/or disclose any Private Health Information as contemplated by HIPPA limited to my claim for insurance benefits and any appeal there from. I have signed a separate HIPPA authorization in the regard.
5. The authorization of Health Care Provider to file a complaint with regard to any denial of my claim(s) with the NJ Department of Banking and Insurance (DOBI), as well as any other governmental agency with jurisdiction over my claim and/or my health insurer.
6. The authorization for payment of any and all health care insurance benefits directly to Health Care Provider to which I might be entitled under the above-mentioned claim.

Patient:_____ Witness: _____

_____ _____

Patient Signature Witness Signature

_____ _____

Date Date