AstranaCare

Assignment of Benefits

It is your responsibility to understand your insurance benefits. If you are not sure if a service or treatment is covered, you should contact your insurance carrier. If your insurance carrier indicates that you have a copayment and/or deductible, that amount is requested at the time you check-in. If there is an additional balance due, you will receive a bill from us.

Insurance Carrier Disclaimer:
A quote of benefits and/or authorization does not guarantee payment or verification of eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service.

Insurance Liability for Payment:
Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures preauthorized by your health insurance company. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service. You are responsible for charges not paid by your insurance carrier(s).

Beneficiary Agreement:

I, _____, understand that my health insurance company may deny payment. **If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.** By signing my name below, I certify that I have read the above information. Any questions regarding these policies have been discussed. My signature also certifies my understanding and agreement with the above policies. A photocopy of this document is as valid as the original. You may receive a copy of this document upon request.

Patient Name (Please Print): _____ **Date:** _____

Patient Signature: _____