University Pain & Spine Center
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ASSIGNMENT OF BENEFITS

I, _____ _____ , the undersigned patient or legally authorized representative, hereby **designate University Pain Medicine Center (UPMC), University Pain & Spine Center (UPSC), New York Pain Medicine Associates (NYPMA), STEMMEE Surgical Center**, and their affiliated providers, facilities, administrative agents, attorneys, and billing representatives (collectively referred to as "Providers") as my **Authorized Representative** for all purposes related to the coordination, administration, and enforcement of my health insurance benefits and medical claims.

This designation includes, but is not limited to, the following rights, powers, and privileges:

Assignment of Benefits: I assign to the Providers all rights and benefits under my insurance policy or health plan, including ERISA-governed plans, for services rendered. This includes the right to, bill, collect, appeal, litigate, or arbitrate denied or underpaid claims in my name or theirs.

Direct Payment Authorization: I authorize my insurance carrier or any responsible third-party payor to remit all payments directly to the Providers. If payment is sent to me in error, I agree to endorse and forward those funds immediately to the Providers.

Insurance Access & Disclosure: I grant the Providers full access to my insurance policy, coverage terms, eligibility information, and claims records. This includes rights to obtain, review, and submit all documents necessary for prior authorizations, appeals, benefit disputes, and reimbursement enforcement. MY CARRIER SHALL NOT INTERFERE/DELAY THE FUFILLMENT OR ISSUANCE OF ANY SUCH REQUESTS MADE BY THE PROVIDERS.

HIPAA Authorization: I authorize the release of my protected health information (PHI) to the Providers and their designated agents, including legal counsel, for treatment, billing, and administrative purposes related to any claim or coverage matter.

Authority to Act: I grant the Providers permission to initiate and pursue **appeals, grievances, arbitration, and legal action** on my behalf for any disputed, delayed, or denied medical claims, and to recover any interest or penalties owed under federal or state law.

Term: This agreement is effective immediately and remains valid unless revoked in writing. It applies to all past, current, and future services provided by the Providers.

_____ _____

Patient or Responsible Party Signature Date