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Assignment of Benefits/Erisa Authorized Representative Form & Limited Power of Attorney Assignment of Insurance Benefits- Appointed as Legal Authorized Representative

I hereby irrevocably assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to **Sundeep Mangla MD, DBA Neurointerventional Medicine PLLC** and their chosen affiliated law firms (hereinafter, "My Authorized Representatives") and I appoint them as my authorized representative with the power to:

- File medical claims with the health plan including filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier and have all medical claims paid Directly to the Authorized Representatives Named herein.
- File appeals and grievances with the health plan
- Institute any necessary litigation and/or complaints against my health plan naming me as plaintiff in such lawsuits and actions if necessary (or me as guardian of the patient if the patient is a minor).
- Discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan. I authorize you and your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such healthcare provider(s) to release all such information to you about me, including medical reports, x-ray reports, narrative reports, and other report or information regarding my physical condition.

I certify that the health insurance information that I provide to Provider is accurate as of the cate set forth below and that I am responsible for keeping it updated. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, coinsurance, and deductibles.

Authorization to Release Information:

I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization:

I hereby designate, authorize, and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. I authorize communication with the Provider and his authorized representatives by email and my email address is ______________________________@___________. I understand I can revoke this authorization in writing at any

time. I direct all reimbursable medical payments go directly to you, **Sundeep Mangla MD, DBA Neurointerventional Medicine PLLC**, "The Practice". I agree to turn over to "The Practice" any checks I receive on behalf of services rendered to me by the providers at "The Practice" and I am aware such payments do not belong to me. I am aware that if I fail to turn over payments to "The Practice" that have been sent to me on behalf of representatives have the right to consider such profiting equivalent to grand theft and prosecute you as one who committed a felony crime. In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is challenged or deemed invalid, I execute this limited/special power of attorney and appoint and authorize your collection attorney as my agent and attorney to collect payments for your medical services directly against the carrier in this case, in my name, including filing an arbitration demand or lawsuit. I Specifically authorize that attorney to file directly against that carrier in my name or in our name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me. I authorize you and or your attorney to receive from my insurer, immediately upon verbal request, all information regarding last payment made by said insurer on my claim, including date of payment and balance of benefits remaining. A photocopy of this Assignment Authorization shall be as effective and valid as the original.

NAME (Last, First, MI) ____

SIGNATURE: ____DATE:________________

SIGNATURE ON FILE-MEDICARE

I request that payments of authorized Medicare benefits be made on my behalf to **Neurointerventional Medicine PLLC** for any services furnished to me by **Neurointerventional Medicine PLLC**. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorized release of medical information necessary to pay claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or else- where on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the issuer or agency shown.

Neurointerventional Medicine PLLC agrees to accept the charge determination of the Medicare carrier, and if available and appropriate Secondary Supplemental Insurance Provider, as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

SIGNATURE: ____ DATE:________________