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CENTRAL JERSEY AMBULATORY SURGICAL CENTER

511 Courtyard Drive, Hillsborough, New Jersey, 08844
Bldg.500 - 1st Floor · Phone: 908-895-0001 · Fax: 908-685-8833

PAYMENT AUTHORIZATION

I HEREBY AUTHORIZE AND DIRECT MY INSURANCE TO PAY DIRECTLY CENTRAL JERSEY AMBULATORY SURGICAL CENTER. ANY BENEFITS FOR THE AMBULATORY SERVICE(S) RENDERED TO ME OR MY DEPENDENT UNDER MY INSURANCE PLAN. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. I ALSO AUTHORIZE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

_____ IN NETWORK

I AM SCHEDULED FOR A PROCEDURE AT CENTRAL JERSEY AMBULATORY SURGICAL CENTER. THEY ARE IN NETWORK WITH YOUR INSURANCE. YOU ARE RESPONSIBLE, IF YOU HAVE ANY IN NETWORK **FACILITY DEDUCTIBLE, CO-INSURANCE** AND **COPAY**. THEREFORE YOU WILL RECEIVE A BILL. IF YOU DO NOT KNOW YOUR **FACILITY** BENEFITS, PLEASE CALL YOUR INSURANCE COMPANY PHONE NUMBER ON THE BACK OF YOUR CARD, SO YOU WON'T BE SURPRISED IF YOU RECEIVE A BILL.

_____ OUT OF NETWORK

I AM SCHEDULING FOR A PROCEDURE AT THE CENTRAL JERSEY AMBULATORY SURGICAL CENTER. SINCE THE FACILITY IS NOT CONTRACTED WITH MY INSURANCE COMPANY, THE REIMBURSEMENT MAY BE SENT TO ME INSTEAD OF THE CENTER. UPON RECEIPT OF THE INSURANCE PAYMENT, I WILL **FORWARD THE CHECK AND THE EXPLANATION OF BENEFITS TO THE CENTER.** MY INSURANCE PLAN MAY STILL HOLD ME RESPONSIBLE FOR A DEDUCTIBLE AND/OR CO-INSURANCE

_____ _____
PRINT NAME OF PATIENT BIRTHDATE

_____ _____
SIGNATURE OF INSURED/AUTHORIZIED PERSON DATE

_____ _____
WITNESS DATE