



## Assignment of Benefits' Credit Card on File Agreement

In being a non-contracted provider with your insurance carrier, payments for our services may be sent directly to you or the insured. Therefore, it is our policy that any patients who may receive these payments leave a credit card on file to be used ONLY in the event that such payments are not recovered.

If your credit card is charged for non-recovered payments, a paid invoice and copy of the receipt will be sent to you for your records.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

Credit Card: Please circle one

Visa   Mastercard   American Express   Discover   Debit Card

Card#: \_\_\_\_\_ Exp.: \_\_\_\_\_

Signature of File: \_\_\_\_\_

Thank you for cooperation.

611 Broadway, Suite #503  
New York, NY 10012  
P (212)254-7750  
F (212)254-1202



# Oxford Health Plans®

## VOLUNTARY PRIOR APPROVAL PROCESS AGREEMENT

I hereby request that Oxford review the attached care plan for my proposed treatment from:

Provider's Name and Group (if applicable): \_\_\_\_\_

Provider's Address: \_\_\_\_\_

to determine whether to cover the services described in the care plan when provided to me by the named provider or other providers in the group. In making this request, I agree:

1. That Oxford will make a coverage determination for the services described in the care plan, and that this coverage determination will apply to all of the services described in the care plan. Oxford will not conduct a separate review of coverage for the service described in the care plan if a claim is submitted for the service after the service is received. Oxford may contract with other parties to make or assist it in making the coverage decision, as permitted by applicable law.

2. That if Oxford decides that some or all of the services described in the care plan will be covered, the services will **only** be covered as long as I am an Oxford Member **and** the services are received from the provider named above. I understand that Oxford's decision to cover the services means that Oxford will pay the out-of-network provider named above in accordance with my certificate and Oxford's standard policies and procedures. I will be responsible for paying applicable deductibles, coinsurance and charges in excess of the usual, customary and reasonable charge. If I obtain services when I am no longer an Oxford Member, coverage will be denied. If I change providers, and I do not submit a new request for voluntary prior approval, Oxford will make coverage decisions when claims are submitted.

3. That if Oxford does not have clinical information required to make a coverage decision regarding some or all of the services described in the care plan, that I must provide the required information within 45 days from the date that Oxford notifies me that it requires clinical information or coverage will be denied.

4. That if Oxford approves coverage for some, but not all, of the services described in the care plan, that I may either (a) obtain the services that were approved and submit a request for an extension of coverage after the last approved visit, or (b) appeal the services for which coverage was denied, as described in paragraph 5.

5. That if Oxford denies coverage for some or all of the services described in the care plan, I may appeal at any time within 180 days of my receipt of the denial (225 days if I receive a notice that additional clinical information is required and I do not provide the required clinical information) by following the procedures described in my Certificate of Coverage. I understand and agree that if I appeal, the appeal will include all issues relating to the denial of coverage, including denials of claims for the services, which are the subject of the appeal, and requests for extension of coverage.

6. That I am entitled to submit a denial of coverage made under this process for review under the "external appeals" process described in my Certificate of Coverage.

7. That, if Oxford denies coverage for any service described in the care plan, I will be responsible for paying the non-participating provider for such services, unless I appeal and the decision on appeal is that Oxford will cover the services.

8. That this process is voluntary, and that I am agreeing to the process as described above. This agreement applies only to services described in the care plan and any request for extension of coverage that I might make. Oxford will review coverage for services not described in the care plan when a claim is submitted.

Member's Printed Name: \_\_\_\_\_ Member's Oxford ID Number: \_\_\_\_\_

Signature: \_\_\_\_\_  
(Parents or legal guardians may sign for minors)

Date: \_\_\_\_\_

**PLEASE SEND THIS FORM DIRECTLY TO ORTHONET BY FAX AT 866-733-7871, OR MAIL TO:  
ORTHONET P.O. BOX 5021, WHITE PLAINS, NY 10602-5021, ATTN: Voluntary Prior Approval Program  
6001 MS-02-1428**