PREMIER
Orthopaedic Associates

Patient Information Form

Patient's Legal Name _____ DOB ____ /____ /____ SS# ____ - ___ - _____
Address _____ Apt/Lot _____ City _____ State _____ Zip _____
Email _____ Home Phone ____ - ____ - _____ Cell Phone ____ - ____ - _____
Gender: Male Female Marital Status: Married Single Divorced Widowed
Pharmacy Name: _____ Pharmacy Address: _____
Payment Type: Self Pay ____ Insurance ____ Insurance Company: _____
Subscriber Name _____ Relationship to Patient _____ DOB ____ /____ /____
Address _____ SS# ____ - ___ - _____ Phone ____ - ____ - _____
Responsible Party Name _____ Relationship to Patient _____ DOB ____ /____ /____
Address _____ SS# ____ - ___ - _____ Phone ____ - ____ - _____
Employer Address _____
Emergency Contact _____ Phone ____ - ____ - _____ Relationship to Patient _____
Referring Physician _____
Primary Care/Family Doctor _____

PAST MEDICAL HISTORY – MEDICAL CONDITIONS (CIRCLE ALL THAT APPLY):

Migraines
Alzheimer's/Dementia
Parkinson's
Anxiety/Depression/Bipolar
Atrial Fibrillation
Mitral Valve Prolapse
Aortic Stenosis
Congestive Heart Failure
Cerebrovascular Accident (Stroke)
Myocardial Infarction (heart attack)
Coronary Artery Disease
Pacemaker/Defibrillator/Heart
Stents
Hypertension

Peripheral Vascular Disease
Thyroid Disease: Hypo – Hyper
Fibromyalgia
Systemic Lupus Erythematosus
Asthma
COPD/Emphysema
Obstructive Sleep Apnea, Use of CPAP – Y or N
Diabetes: Type 1 – Type 2
Anemia
HIV/AIDS
Hepatitis: A – B – C
DVT (blood clot): Y or N
If yes, where: _____

High Cholesterol
MRSA: Active - Inactive
End Stage Renal Disease, Dialysis: Y or N
Renal Insufficiency
Liver Cirrhosis
Gastric Ulcers
GERD
Cancer: Y or N
Type: _____
Osteoarthritis
Body Part: _____
Osteoporosis
Other: _____

How did your injury occur: At work: Y or N Motor Vehicle Accident: Y or N Date of Injury ___ /___ /___
Past Surgical History (please list any since last visit): _____

_____

Medications with Dosage (include Herbs, Vitamins/Supplements, OTC medications): _____

_____

Do you take any of the following: Coumadin ____ Plavix ____ Aspirin ____

Allergies (medications & foods): _____

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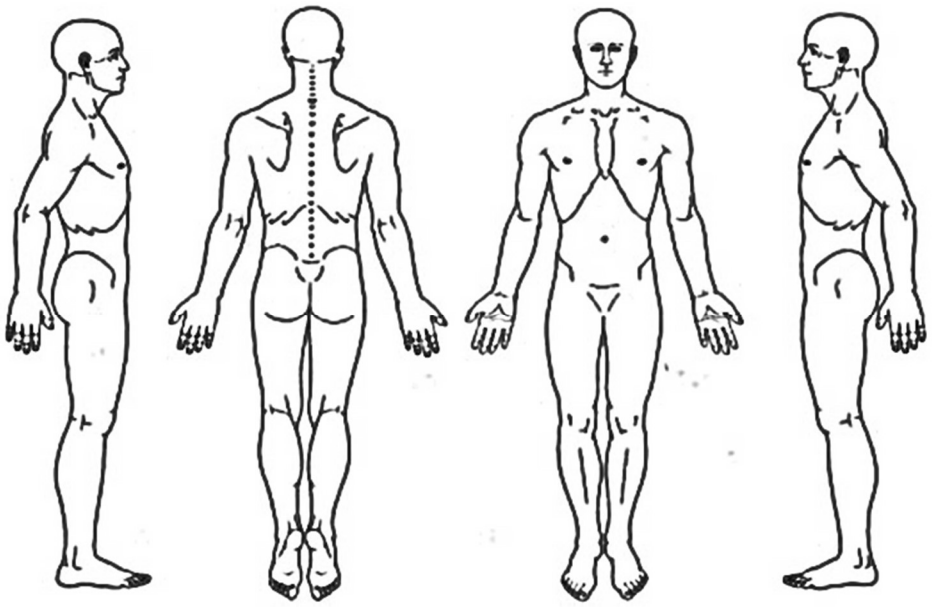
Rahul V. Shah, MD



Name : _____

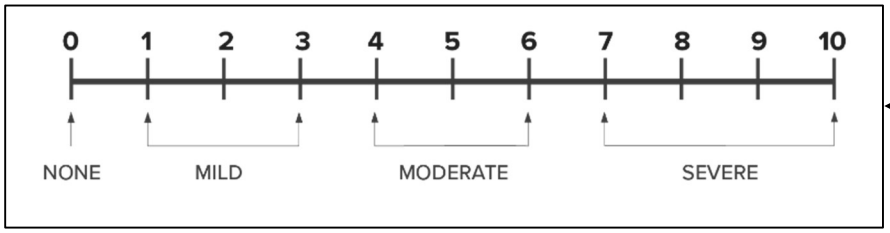
Date : _____

Age : _____

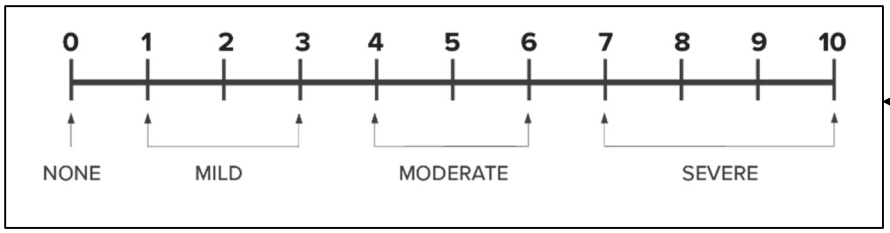
Referring Dr. : _____

If you feel discomfort, please mark on the drawings with the type of discomfort you feel.

Burning discomfort **xxxxxx**
Deep Ache ☐☐☐☐☐☐
Pins & Needles **//////**
Stabbing discomfort **ZZZZZ**
Numbness **--------**



Circle your current level of BACK/NECK discomfort



Circle your current level of ARM/LEG discomfort

When and how did your discomfort start?

_____

_____

Is the discomfort getting (check 1 box)

☐ better ☐ worse ☐ same

What activities INCREASE your discomfort?

_____

What activities DECREASE your discomfort?

_____

Have you had to miss work because of this?

☐ Yes - How long? _____ ☐ No

Have you had this discomfort before?

☐ Yes - When? _____ ☐ No

Does this discomfort wake you from sleep?

☐ Yes ☐ No

Have you tried?

☐ Medicines ☐ Injections ☐ Therapy ☐ Chiropractor

☐ Injections ☐ Surgery ☐ Other: _____

What studies have you had done for this?

☐ X-rays ☐ MRI ☐ CT ☐ Myelogram ☐ EMG

☐ Other : _____

Conservative Treatment History Form

PREMIER Orthopaedic Associates

Conservative treatment is an important part of your medical documentation. It is required to establish medical necessity for further testing and treatment, and will be used for those purposes.

Please be specific and print clearly. Authorization may be delayed if informaiton is illegible or missing.

Today's Date: Patient Name: Date of Birth:		
How long have you had symptoms for the treatment you are seeking?		
Have you tried any of the following treatment?		
Physical Therapy?	**YES** **NO** (Circle One)	
If yes, Where_____ Address _____ Month/Year of first session? _____ Month/Year of last session? _____ How Many Sessions: _____ How do you feel after doing therapy? **BETTER** **SAME** **WORSE** (Circle One)		
Chiropractic Care?	**YES** **NO** (Circle One)	
If yes, Where_____ Address _____ Month/Year of first session? _____ Month/Year of last session? _____ How Many Sessions: _____ How do you feel after doing therapy? **BETTER** **SAME** **WORSE** (Circle One)		
Physician Recommended home exercises for this problem:	**YES** **NO** (Circle One)	
If yes, please complete this section. What type of exercises? _____ Who gave you the exercise plan? _____ Month/Year you began exercises? _____ Month/Year you completed exercises? _____ How many times per week do you exercise? _____		
Are you currently engaged in a physical therapy, chiropractic or home exercise program?	**YES** **NO** (Circle One)	
Have you received any of the above since your last injection?	**YES** **NO** (Circle One)	
If YES, please describe your physical therapy, chiropractic or home exercise program since your last injection:		

This form, signed and completed, will be part of your medical record. When documentation of Conservative Treatment is required, this form along with all documents requested, will be supplied.

Signature:

Patient: **Date:**

PREMIER
Orthopaedic Associates

FINANCIAL POLICIES

Thank you for choosing Premier Orthopaedic Associates of Southern New Jersey (POASNJ) for your orthopaedic care. We are committed to the process of your medical treatment and care. Please understand that payment of your bills is part of this treatment and care.

REFERRALS: If you have an HMO plan that we are contracted with, you need a referral from your PCP authorizing your treatment. If we have not received the referral prior to your arrival at the office, you may use the telephone available to contact your PCP to obtain it. If you are unable to obtain the referral for your visit, you may be rescheduled or required to fill out and sign your responsibility waiver which makes you financially responsible for all charges incurred on your visit. (*emergency cases only)

YOUR FINANCIAL RESPONSIBILITIES

Our office will file insurance claims for all reimbursable services, to your primary and secondary insurance carriers. Please remember that you are responsible for all deductibles, copay, co-insurance, and non-covered service amounts. We accept payment by cash, check, visa, or MasterCard.

You will receive billing statement(s) from our office for the account balances that are your responsibility. Balance in full is due withing 15 business days. If the patient portion of your account is not paid in a timely manner, legal collection efforts will be made. All legal collection fees incurred to collect the patient balances will be the responsibility of the patient.

HMO, POS, and PPO plans that POASNJ contracts with: If the services you receive are covered by the plan and you have provided any required referral and /or authorization, you are responsible for all applicable copays and deductibles. These are to be paid at the time of service. If the services are not covered by the plan payment is full in required at the time of service.

Commercial Insurance or PPO's that POASNJ does NOT contract with: POASNJ will submit your claims to your carrier as a courtesy. If all current and accurate information is provided, you will be billed for any remaining balances with the total amount due within 15 days of billing. It is the responsibility of the patient to contact your insurance to verify if our office is contracted with your carrier.

Medicare: You will be responsible for any portion of your deductible that is not paid or covered by your secondary insurance. You will be responsible for any services not covered by Medicare. POASNJ will submit Medicare and secondary claims. All patient balances remaining after Medicare and/or secondary payments will be billed to you and will be due within 15 days of billing by this office.

Medicaid: POASNJ physicians are NOT participating in NJ Medicaid. Payment is required at the time of service. We will work with you to arrange a payment plan. This will be determined on a case-by-case basis. Please request to speak to a billing representative to discuss a possible self-pay patient discount, and/or payment plan.

NO Insurance: Payment in full is required at the time of service. If you have financial hardships, we will work with you to arrange a payment plan. This will be determined on a case-by-case basis. Please request to speak to a billing representative to discuss a possible self-pay discount and/or payment plan.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copays and deductibles, are my responsibility. I authorize the release of any information concerning me or my child's healthcare for the purpose of evaluating and administering claim for insurance benefits and to my primary care physician.

I authorize my insurance benefits be paid directly to Premier Orthopaedic Associates of Southern New Jersey, (POASNJ). I authorize Medicare benefits to be paid directly to Premier Orthopaedic Associates of Southern New Jersey (POASNJ). I authorize any holder of medical information about me to release the centers of Medicare and its agents any information needed to determine these benefits or the benefits payable for related services.

_____	_____	_____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY	PRINTED NAME OF PATIENT/RESPONSIBLE	DATE

PREMIER
Orthopaedic Associates

OPIOID PAIN MEDICATION AGREEMENT

Patient Legal Name: _____ **Date of Birth:** ___ /___ /___ **Date:** ___ /___ /___

I understand that _____ (clinician name) may prescribe opioid medication to assist me in managing chronic pain. I understand the risks, side effects, and benefits, and I agree to the following conditions of opioid treatment.

1. The medication must be safe and effective and help me to function better. The goal is to use the lowest dose that is both safe and effective. If my activity level or general function gets worse, the medication will be changed or discontinued by my clinician.
2. I will participate in other treatments that my clinician recommends and will be ready to taper or discontinue the opioid medication as other effective treatments become available.
3. I will take my medications exactly as prescribed and will not change the medication dosage or schedule without my clinician's approval.
4. I will keep regular appointments and will call at least 24 hours in advance if I have to reschedule.
5. One clinician. All opioid and other controlled drugs for pain must be prescribed by the clinician who is named above. I will not obtain medications from other clinicians or pharmacies unless I am hospitalized. I will tell any hospital or emergency room clinicians that I receive pain medications from my provider. In the event of an emergency, if I am given a prescription for pain medication, I will notify my primary clinician as soon as I am able.
6. One pharmacy. I will designate one pharmacy where all my prescriptions will be filled. I am responsible for prescriptions being filled on time. To avoid running out of my medications, I will contact my provider's office at least 3 business days in advance for refills. I understand that prescriptions generally will not be sent by mail or faxed.
7. I understand that lost or stolen prescriptions will not be replaced, and I will not request early refills.
8. I agree to abstain from excessive alcohol use and all illegal and recreational drug use and will provide urine or blood specimens at the clinician's request to monitor my compliance.
9. I understand that my health information may be exchanged with other health care practitioners and pharmacists to assist in my treatment, including pain management and utilization of pain medication.
10. I understand that clinic staff (nurses, receptionist, lab staff, etc.) are very important in my success with this treatment plan. I will treat them respectfully and abide by their decisions regarding my care and the enforcement of this agreement.
11. If I am unable to follow the conditions of this agreement, I understand it may not be safe for me to continue the medication.

Patient Signature: _____ Date: _____ /_____ /_____ Time: _____

Clinician Signature: _____ Date: _____ /_____ /_____ Time: _____

Pharmacy: _____

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RELEASE OF INFORMATION AUTHORIZATION FORM

I, _____ give my _____
Patient's Name ***Relationship to Patient***

_____, permission to:
Name of person receiving PHI

PLEASE CHECK ALL THAT APPLY:

_____ MAKE & RECEIVE PHONE CALLS REGARDING MY OR MY LEGAL DEPENDENT'S PHI (Protected Health Information) IN MY ABSENCE.

_____ PICK UP FORMS, PRESCRIPTIONS, REFERRALS, &/OR SAMPLES FOR ME OR MY LEGAL DEPENDENT IN MY ABSENSE

_____ RECEIVE BILLING INFORMATION

Please include any additional individuals to be included for the above:

_____
Name Relationship

_____
Name Relationship

_____
Name Relationship

I understand that this authorization will remain in effect unless/until I change it in writing. I understand that I may change or rescind this authorization at any time in writing.

By signing this document I also give my authorization for any POASNJ staff member or doctor to leave messages on my answering machine or voicemail.

Signature: _____ Date: ____ /____ /____

PREMIER ORTHOPAEDIC AND SPORTS MEDICINE ASSOCIATES OF SNJ, LLC
PREMIER ORTHOPAEDIC SPINE ASSOCIATES, LLC
PREMIER ORTHOPAEDIC SURGICAL CENTER, LLC

HIPAA & NOTICE OF PRIVACY PRACTICES

PATIENT DETAILS:

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: _____ /_____ /_____

Gender: Male Female Prefer not to say Marital status: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES (THE "NOTICE") DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS INFORMATION CAREFULLY.

WE CONSIDER THE PRIVACY OF YOUR HEALTH INFORMATION OF PARAMOUNT IMPORTANCE.

OUR LEGAL DUTY

As a recipient of health care services, you have certain rights. To learn more about these rights, we suggest you visit: https://www.hhs.gov/hipaa/for-individuals/index.html. We are required by law to maintain the privacy of your health information. We are also required to give you this Notice abut our privacy practices, our legal duties and our rights concerning your health information. We will follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will make commercially reasonable efforts to change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

OUR USE AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you only as necessary for treatment, payment, and our healthcare operations. For example:

TREATMENT: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

PAYMENT: We may use and disclose your health information to obtain payment for services we provide to you.

HEALTH CARE OPERATIONS: We may use and disclose your health information in connection with our healthcare operations. Health care operations including without limitation, quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payment, or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us a written authorization, you may revoke it in writing at any time, although such revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we will not use or intentionally disclose your health information for any reason except those described in this Notice.

TO YOUR FAMILY AND FRIENDS: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree in writing that we may do so.

PERSONS INVOLVED IN CARE: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, concerning your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will (1) disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care and (2) use our professional judgment and experience with common practice to make reasonable inferences of your best interest in allowing third parties to pick up prescriptions, medical supplies, x-rays, or other similar forms of health information.

MARKETING HEALTH-RELATED SERVICES: We will not use your health information for marketing communications without your written authorization.

REQUIRED BY LAW**:** We may use or disclose your health information when we are required to do so by law.

ABUSE OR NEGLECT**:** We may disclose your health information to appropriate authorities if we reasonably believe that you may be a victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

NATIONAL SECURITY**:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials' health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders.

PATIENT RIGHTS

ACCESS: You have the right to review or obtain copies of your health information, with limited exceptions. You may request copies in a format other than photocopies. We will use the format your request unless we cannot practically do so. You must make a request I writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice.

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which we or our business associated disclosed your health information for purposes, other than treatment, payment, health care operations, and certain other activities, for the last 6 years. We will provide such a list at no charge upon your request once in any 12-month period. We reserve the right to charge you for requests in excess of one per 12-month period.

RESTRICTIONS: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide a satisfactory explanation of how payments will be handled under the alternative means or location you request.

AMENDMENT: You have the right to request that we amend your health information. (Any such request must be made in writing and must explain why the information should be amended). We may deny your request under certain circumstances.

ELETRONIC NOTICE: If you receive this Notice on our website or by electronic mail (email) you are entitled to receive this Notice in written form upon request.

QUESTIONS AND COMPLAINTS

To learn more about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, or in response to a request you made to amend or restrict the use or disclosure of your health information, or to have us communicate with you by alternative means or at

alterative locations, you may contact us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to privacy of your health information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

ACKNOWLEDGEMENT: I hereby acknowledge that I have read and fully understand the contents of this document and I have been given the opportunity to ask any and all questions.

If patient is a minor,

Guardian's relationship to patient:

Address:

City: State: Zip Code:

For any questions regarding this policy, please contact:

Alexsandra Gonzalez
HIPAA Compliance Officer
agonzalez@poasnj.com
(856) 690-1616 ext. 3030

***By signing below, I acknowledge that I have read and understand this practice's Notice of Privacy Practices*

Patient Signature _____ Date: _____ /_____ /_____

New Jersey Department of Banking and Insurance

CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary.* This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY, does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS

I, PRINT NAME, by marking [√] (or [x]) and signing below, agree to:

[X] representation by [ ] in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.

[X] release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: _____ Ins. ID#: _____ Date: _____

Relationship to Patient: [ ] I am the Patient [ ] I am the Personal Representative (provide contact information on back)

PHONE: _____ FAX: _____ EMAIL: _____

* If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

New Jersey Department of Banking and Insurance

NOTICE OF REVOCATION OF CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND OF AUTHORIZATION TO RELEASE OF MEDICAL RECORDS

You may, at any time, revoke the consent you gave allowing a health care provider to represent you in an appeal of a UM determination and allowing the release of your medical records to the DOBI, the IURO and medical professionals that contract with the IURO. You may use this form to revoke your consent, or you may submit some other written evidence of your intent to revoke consent, if you prefer. Either way, if you have not yet received a Stage 2 UM determination from the carrier, send the written and signed revocation to the carrier at the address indicated in the carrier's written notice to you regarding the carrier's initial UM determination. If you have received a Stage 2 UM determination, then your revocation should be sent to:

New Jersey Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care – Attn: IHCAP
P.O. Box 329
Trenton, NJ 08625-0329
OR for courier service to: 20 West State Street OR by fax to: (609) 633-0807

You may also want to send a copy of your notice of revocation to the health care provider.

ONLY COMPLETE AND SEND THIS IN WHEN AND IF YOU WISH TO REVOKE YOUR CONSENT!

REVOCATION OF CONSENT TO REPRESENTATION AND RELEASE OF MEDICAL RECORDS IN UM DETERMINATION APPEALS

☐ I hereby revoke my consent to representation by ☐ and my authorization to the release of medical information in an appeal of an adverse UM determination. I understand that by revoking consent, the UM appeal may not be pursued further by my health care provider. I understand that this revocation may occur after my personal and medical information has already been shared with the DOBI, the IUROs and medical professionals with whom the IUROs contract, but that no further distribution of records in this matter will occur based on my authorization, and that all of my medical and personal information is required to be maintained as confidential by all parties.

Signature: _____ Ins. ID#_____ Date:_____

Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative

Contact Information of Personal Representative

Please provide the following contact information IF it is different from the patient's contact information:

PRINT NAME: _____

ADDRESS:_____

_____

PHONE: _____ FAX: _____ EMAIL: _____

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

SUMMARY OF APPEAL
Summarize the Appeal Issues *(attach additional pages if necessary)*:

AUTHORIZATION BY THE COVERED PERSON FOR RELEASE OF INFORMATION

I understand that a copy of this form and any enclosures may be sent to the Independent Utilization Review Organization (IURO) and the Carrier named in the appeal and I authorize the release of any medical and/or administrative records pertinent to this appeal to the IURO selected by the New Jersey Department of Banking and Insurance.

Signature of covered person	Date

I am filing as a health care provider acting on behalf of a covered person with the covered person's consent. I have attached a copy of the relevant Consent to Representation in Appeal of a Utilization Management Determination and Authorization of Release of Medical Records for Appeal and Arbitration of Claims. *To my knowledge and belief, I am authorized to file this application for appeal and to release pertinent medical and/or administrative records to the IURO.*

Signature	Date

New Jersey Department of Banking and Insurance

APPLICATION FOR THE INDEPENDENT HEALTH CARE APPEALS PROGRAM

New Jersey Department of Banking and Insurance
Office of Managed Care
P.O. Box 329
Trenton, NJ 08625-0329
Courier: 20 West State Street

For NJDOBI Use ONLY
Date Rec'd:_____
File No.: _____
Category: _____
IURO: _____

Instructions: Read and complete the entire form (please print or type). The form must be signed and dated. Forward the completed form, including the fee and any attachments, to the address above.

COVERED PERSON/SUBSCRIBER INFORMATION

Name of Covered Person			Covered Person's ID Number
Name of Subscriber			Subscriber ID Number
Street Address of Covered Person	City	State	Zip Code
Home Telephone Number ( )	Business Telephone Number ( )		Medical Record:
Name of Carrier			

Coverage Through: ☐ Employer (State) ☐ Employer (Federal) ☐ Employer (Private) ☐ Individual/Nongroup ☐ Medicare ☐ Medicaid ☐ NJFamilyCare

Attach a copy of the Summary of Insurance Coverage or Schedule of Benefits/Covered Services.

INDIVIDUAL FILING THE APPEAL

Name of Person Filing the Appeal	Filing Type: ☐ Consumer ☐ Provider* **Providers MUST have the consent of the covered person.*

PROVIDER INFORMATION

Name of Health Care Provider			
Street Address	City	State	Zip Code
Name of Contact Person for Provider			Telephone Number ( )

FILING FEE

Please indicate the fee enclosed (there is a $25.00 filing fee except in cases of financial hardship):

☐ $25.00 ☐ Fee waived (submit evidence of financial hardship)

INTERNAL CARRIER APPEAL PROCESS

1. Have you utilized the Carrier's internal appeal process?	☐ Yes	☐ No
a. Have you received a final written decision from the Carrier?	☐ Yes**	☐ No
2. If you checked "Medicare," have you filed an appeal with Medicare?	☐ Yes	☐ No

***Attach a copy of the final written decision*

Name of Covered Person:	Covered Person's ID Number: