Air Methods®

Air Medical Transport Services provided by Air Methods Corporation

DEFENDERS OF TOMORROW™

Assignment of Benefits (AOB)

Please fill out all fields and return in the enclosed postage paid envelope.
For help on filling out the form, contact us at:

(855) 896-9067

patientforms@airmethods.com

ASSIGNMENT OF BENEFITS
*****REQUIRED FOR INSURANCE BILLING*****

RELEASE OF INFORMATION I agree to allow Air Methods Corp., its agents and any of its associated companies (together, "Provider") to share any part of my medical record or other information needed for billing and payment for services delivered by Provider, now or in the future, to any financially responsible party, including: the Centers for Medicare and Medicaid Services (CMS), their agents, Worker's Compensation carriers, health or liability insurers, and any other insurance organization or billing agent (together, "Insurer"). I agree to allow anyone with medical and billing information about me to release to Provider or Insurer any information necessary for billing and payment purposes. I agree a copy of this form may be used instead of the original.

ASSIGNMENT OF BENEFITS & RIGHTS I agree to allow and request any Insurers to directly, immediately and exclusively pay Provider the proceeds of my benefits up to the full amount of Provider's charges for services delivered now or in the future. I assign to Provider all of my rights and interest in all such insurance benefits or proceeds for services delivered by Provider, including the rights to: (1) request and receive any documents or information from any entity or person, including those governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), to the full extent of my rights; (2) appeal any denial or underpayment of benefits or coverage; (3) pursue any legal remedies in any forum and get all available relief (monetary or equitable), including applying all ERISA provisions. These rights assigned to Provider are assigned completely, without any limitations or reservations.

FINANCIAL RESPONSIBILITY I will cooperate with any efforts by Provider to maximize payment of my insurance benefits and minimize my personal financial responsibility. I agree to allow Provider to be my advocate throughout the billing process to help resolve my claim as quickly as possible. If I receive payment from an Insurer for Provider's services, I agree to promptly send such payment to Provider. I understand that many Insurers will only pay for services that meet certain coverage requirements, such as medical necessity. If my Insurer denies or underpays Provider's charges for any reason, or if I have no insurance, I accept direct financial responsibility for any unpaid charges.

COLLECTIONS & TELEPHONE CONSENT I agree to allow Provider to: (1) use pre-recorded or artificial voice messages, or an automatic telephone dialing system, to contact me at the telephone number provided below, which may be a wireless or cell phone number; (2) leave answering machine or voice mail messages for me, and include in any such messages information required by law (including debt collection laws) or other information about amounts I owe; (3) send text messages or e-mails to the telephone number and e-mail address provided below about unpaid balances or other billing issues. I also agree to allow Provider to get a credit report to help collect unpaid balances.

I have read this information and I am the patient, the patient's legal representative or authorized by the patient as the patient's agent to sign this Assignment of Benefits and to accept its terms.

Mark the Appropriate Box and Sign Below:
Signer below is the: ☐ **Patient** ☐ **Insurance Policy Holder** ☐ **Power of Attorney**

Signature: _____ Date: ____/____/_____

Printed Name of Signer: _____ Relationship to Patient: _____

Patient Name (if not signer above): _____ Patient Date of Birth: ____/____/_____

Last four digits of Patient's Social: _____ Phone: _____ Email: _____