Explanation of Forms - please retain this for your records.

Authorization of Representation and Specific Power of Attorney (AOR/POA): The AOR allows our patient advocacy billing partner, Advanced Reimbursement Solutions (ARS) to file claims and appeals with your health plan, request documents that are relevant to your claim, and communicate with the plan on your behalf to ensure that your claim is properly paid. The AOR is allowable under Federal Law and regulations. The POA appoints our patient advocacy billing partner and their employees to sign and complete forms on your behalf as it relates to the claims process, appeals and communicate with your health plan administrator. For Example, an insurance company may require a specific form to be completed for processing of the claim or you may have forgot to sign a document necessary to process your claim. The POA allows our billing partners to sign, correct and complete these forms on your behalf. Since it is specific, our billing partner is limited to signing, completing and correcting documents only relating to processing of your claim(s)

Authorized Representative Service Agreement (ARSA): The ARSA sets forth terms and conditions of this authorized-representative relationship. Additionally, it explains your duties to fully cooperate with the processing of claims. For example, occasionally, an insurance carrier will mail a check to you that was intended to pay for your health care. This form allows you to bring the check to the provider for processing. Cashing of the check or depositing without paying your health care provider maybe actionable under state or federal criminal or civil laws. This agreement also explains your ability to terminate the relationship.

Authorization for Use and Disclosure of Protected Health Information: This document allows, your insurance carrier and your providers to release and share health information related to the processing of your claim. Including records, bills and explanation of benefits.

Election of Out-of-Network Benefits (EONB): Your healthcare benefits allow you to use in-network or out-of-network benefits. The EONB notifies your healthcare plan that you have chosen to use the "out of network" benefits portion of your plan. These are services you pay for through your health plan. After careful consideration, you have determined that the out-of-network services, devices and quality of care are beneficial for a healthy and speedy recovery.

Assignment of Benefits: By signing this document, you are directing your insurance company or plan to directly pay your provider for services rendered. Should you receive any benefit checks from your insurance company or plan, you are agreeing to endorse that check to your medical provider. **BCBS most commonly issues benefit checks to you, the patient. If you have BCBS, please be especially alert to all incoming correspondence and mailings from your insurance company.**

Explanation of Benefits: You should receive this document from your insurance carrier 45-60 days after the procedure. **THIS IS NOT A BILL**. They are computer generated forms which often do not accurately reflect amounts paid, billed or owed. Based on past experiences with health insurance companies, these EOB's are frequently incorrect. Additionally, your insurance carrier may send other documents you did not request. These documents can be confusing please consult ARS if you have any questions

Payment of Co-pay and deductible: If your claim is processed and paid correctly by your insurance carrier your provider will contact you to satisfy and arrange your co-pay or deductible, if any. As your AOR, you can be assured that we are handling the process of coordinating your benefits. Rest assured if we require any documents or have any questions regarding the proper adjudication of your claim a representative will be in touch. If your claim is legally processed and paid correctly according to your plan and carrier, your provide will contact you to pay the remaining deductible and coinsurance.

*****If you have any questions regarding your Out Of Network Insurance information, please feel free to call the PATIENT CHOICE DEPARTMENT at 844-326-3127 and view our website WWW.PATIENT-CHOICE.US.***

AUTHORIZATION OF REPRESENTATION AND SPECIFIC POWER OF ATTORNEY
Relating to Healthcare Benefits

I. IDENTIFYING INFORMATION

Patient Name: _____ Patient Date of Birth: _____

Insurance Carrier: _____ Member ID: _____

Group #: _____ Subscriber ID or S.S. #: _____

Primary Subscriber Name: _____ Primary Subscriber Date of Birth: _____

Primary Subscriber Employer: _____
(If insurance plan is not through employer, write "self")

Primary Subscriber Employer Address: _____
(Street) (City) (State) (Zip)

II. AUTHORIZATION OF REPRESENTATION

I _____, hereby appoint Advanced Reimbursement Solutions, L.L.C. (ARS) and/or Gregory B. Maxon Maldonado, President of ARS (collectively known as my "Authorized Representative") to act on my behalf, as my Authorized Representative, as permitted under Department of Labor Regulation Section 2560.503-1, in connection with the processing of claims, communicating with the Plan Administrator and/or Fiduciary, and/or appeals relating to services and/or products that I received from my Surgery Center, Physician, Medical Group, Durable Medical Equipment Provider and/or any other medical expenses (collectively known as "Services/Products") I have incurred within two (2) years prior to and after the date of the execution of this authorization.

I authorize my Authorized Representative: (a) to communicate with me through email and/or text message regarding any and all matters related to scheduling my healthcare Services/Products and any and all matters related to billing for my healthcare Services/Products to the email and phone number on file; (b) to submit claims for my healthcare Services/Products to insurance companies, health plans, my employer-sponsored health plan's plan administrator, trust, self-funded plans, third party administrators, re-pricing companies, federal and state payers, and all other types of governmental and commercial payers on my behalf; (c) to pursue appeals of denials or underpayments of claims at all administrative levels, including (but not limited to) informal, internal and external appeals or reviews; (d) to request and receive documentation and information necessary to pursue collection of such claims; (e) to pursue any and all legal action and all legal remedies to which I am entitled regarding such claims including (but not limited to) recovering any underpayments or denials of payments, including claims for interests, penalties, breach of fiduciary duty, and punitive damages; (f) to resolve or settle any claims on my behalf; (g) to receive payments from all governmental and commercial payers on my behalf, and; (h) to retain an attorney to represent my Authorized Representative.

In furtherance of my Authorized Representative pursuing health benefit claims and appeals on my behalf, and any other administrative remedies to which I am entitled, under both state and Federal laws; I authorize my Authorized Representative to receive all information, from any source, to pursue such claims, appeals, and legal actions. Additionally, I authorize the hiring of an attorney, at ARS's, cost, as necessary to pursue benefit claims, appeals of adverse benefit determinations and any applicable legal actions on my behalf. I authorize a copy of all information, correspondence and notifications, including but not limited to Explanations of Benefits, claim denials and approvals, and appeal denials and approvals relating to the Services/Products to be sent to Advanced Reimbursement Solutions, L.L.C., 2801 Centerville Road, First Floor, PMB #550, Wilmington, DE 19808.

This Authorization of Representation is effective as of the date signed below and will expire after claims within the Service Period are fully adjudicated or litigated as permitted under state and federal law. I understand that sometimes I may go to the same provider multiple times. This Authorization and Specific

Power of Attorney may be used and relied upon repeatedly and universally until its expiration. I understand that I may revoke this Authorization or the Specific Power of Attorney at any time by informing my Authorized Representative in writing. All correspondence and communications relating to the Services/Products should be directed to my Authorized Representative. Any change in my intent relative to this Authorization will be communicated by me in writing.

If any insurance company, health plan, trust, self-funded plan, third party administrator, re-pricing company, federal and state payer, or governmental or commercial payer requires a specific form be filled out to appoint an authorized representative or any other forms related to Protected Health Information, please forward those forms, along with any plan language requiring I use such forms to ARS. The signing of this Authorization of Representation and Specific Power of Attorney evidences my intent to appoint ARS and/or Gregory B. Maxon Maldonado as my authorized representative and my attorney-in-fact.

I understand I have a duty to cooperate with ARS or its retained counsel in the processing of claims, appeals and interactions with my employer, if necessary. Revocation of any of the forms necessary to fully and properly adjudicate a claim may result in all outstanding balances being owed by the beneficiary. A price list of all services billed is available upon written request.

III. SPECIFIC POWER OF ATTORNEY

This specific power of attorney is effective as the date below and will continue to be effective two years from date entered below or when the claim is paid in its entirety, whichever is first. Any third party who receives a copy of this document shall unequivocally accept instructions from my attorney-in-fact as if given directly by me.

To the extent any dispute arises between Authorized Representative, the Third Party Administrator (TPA), the health insurance carrier, and/or my Plan and/or its fiduciaries relating to a Benefit Claim or the manner in which similar claims will be treated by the TPA, including Plan Administrator and/or its fiduciaries now or in the future, it is my intention that the Plan and/or its fiduciaries give Advanced Reimbursement Solutions L.L.C. on my behalf any and all claims, rights, appeals and causes of actions that I could bring pursuant to Employment Retirement Income Security Act (ERISA) and the Patient Protection and Affordable Care Act (PPACA). This SPECIFIC POWER OF ATTORNEY grants the following:

- Ability for ARS, or its agents or representatives to sign, endorse and complete on my behalf any settlement agreements, releases, checks, and/or other documents necessary to properly and completely execute any Authorization of Representation and/or Protected Health Information (PHI) forms and any and all corresponding claims.
- To claim on my behalf any benefits, reimbursements, damages, excise taxes and awards
- Directly communicate with the Plan Administrator of my employer.
- Direct the Third-Party Administrator to mail checks directly to ARS for processing
- To edit, complete, and/or fill out any Insurance carrier forms necessary to adjudicate the claim, appeal the claim, or interact with my employer or Insurance carrier

IV ACKNOWLEDGMENTS

By signing this form, I understand that I have been given an opportunity to have an attorney or other advisor review the documents and am knowingly waiving my right to have an attorney or other advisor review the documents. I further agree that a photocopy of this agreement shall be as effective and valid as the original. I also certify that I have read and understand the above statements and that all of my questions have been satisfactory answered.

I understand that if I would like additional time to have an advisor or an attorney review these forms, I have the option to reschedule the procedure(s) or set-up and at my own cost have all documents reviewed and explained to me by my attorney or advisor.

Additionally, I understand that I have a continuous and ongoing duty to timely cooperate with ARS during the processing of my claim and all subsequent appeals. Failure to cooperate with ARS may result in the insurance company fully or partially denying payment of the claim. If a full or partial denial of the claim occurs because I fail to cooperate, I understand that I may be responsible for the full payment of the claim

This Authorization of Representation and Specific Power of Attorney is effective as of the date signed below and will continue to be effective until claims relating to the Services/Products are paid in their entirety or for two years whichever comes first.

All correspondence and communications relating to the Services/Products should be directed to my Authorized Representative. Any change in my intent relative to this Authorization or Power of Attorney will be communicated by me in writing.

_____ _____

Signature of Beneficiary/Participant Date

_____ _____

Witness Date

By signing below, Advanced Reimbursement Solutions, L.L.C. and/or Gregory B. Maxon Maldonado hereby accepts the appointment to serve as Authorized Representative and Specific Power of Attorney as described above.

By: 

Gregory B. Maxon Maldonado
(602) 773-1478

Assignment of Benefits

Assignment of Medical Benefits and Payment Responsibility to Provincial Park Surgery Center, LLC (hereinafter referred to as "Providers"). I, the undersigned patient ("Patient"), acknowledge that Providers reserve the right to use the services of Advanced Reimbursement Solutions (hereinafter referred to as ARS) upon Providers' discretion for any part of the claims procedure.

1. **Legal Assignment of Insurance Benefits**: In exchange for and in connection with any and all of the service(s) provided to me ("Services") by Providers, I hereby irrevocably assign to Providers all of my rights, benefits, privileges, protections, claims and any other interests of any kind whatsoever, without limitation, including, without limitation, direct payment to Providers for the Services, appeal rights, rights to fiduciary duties, rights to sue, rights to payment, rights to penalties or interest, rights to plan documents, and rights to information, notices and disclosures from any source, (collectively "Rights") that I had, have or may have in the future pursuant to or in connection with any insurance plan, health benefit plan, trust, fund or any other source of payment, insurance, indemnity or health or medical coverage of any kind (collectively "Health Coverage"), such that I am hereby transferring all and retaining none of these Rights under any Health Coverage to which I am now, previously, or may be entitled to in the future. Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, I instruct my applicable insurance plan, health benefit plan, trust, fund or any other source of payment, insurance, indemnity or health or medical coverage of any kind to please advise and disclose to Providers in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived on any pending claims for benefits under the respective policies. I agree that, should the amount received be insufficient to cover the entire claim I will be responsible for payment of any coinsurance and/or deductible that remains unpaid by my health insurance company, workman's compensation plan and/or auto accident insurance; I will be responsible to Providers for payment of the entire invoice. 2. **Denial of Claim**: I understand that Providers will make every effort to obtain payment for all health care services or products provided by Providers from my insurance company. I agree that I will be jointly and severally financially responsible for any portion of the Providers invoice that is not paid; I understand that I am responsible for any health insurance deductibles and co-payments; I hereby irrevocably assign the benefits payable for any services rendered by Providers to me and authorize Providers to submit a claim to any medical insurance company that I may have for payment to Providers. 3. **One Time Claim Submission**: I understand that Providers will make every effort to obtain payment for all services and or products provided by Providers. I understand that Providers will submit a clean claim one time only and if the claim is not paid, in whole or in part, by my workman's compensation plan and/or auto accident insurance, Providers will look to me for payment of any Providers services and/or products supplied to me. I agree that I will be jointly and severally financially responsible for any portion of the claim, in whole and in part, that is not paid. 4. **I** certify that the information given by Patient to Providers in applying for payment to my workman's compensation plan and/or auto accident insurance or any other medical insurance that I may have, is correct. I agree that if assigned insurance benefits owed to Providers by me are paid to me, I shall immediately notify Providers of such, and immediately endorse benefits check to Providers. 5. **Appointment as Authorized Representative And Right to Sue**: I hereby designate Providers's designated billing company ("Advanced Reimbursement Solutions, LLC" or "ARS") as my duly authorized representative in connection with all matters arising from or relating to Services, Rights and Health Coverage, such that ARS completely and without reservation stands in my shoes and takes my place for all purposes, and is granted absolute power and legal authority to do, seek, claim, appeal or obtain anything that I would have been entitled to do, seek, claim, appeal or obtain in my own capacity pursuant to or in connection with the Services, Rights or Health Coverage, in any legal, private, administrative, formal or informal process or forum whatsoever and without limitation, including any internal or external appeal, review, grievance or any other process, procedure or entitlement under any Health Coverage. 6. **Agreement to Cooperate**: In addition, I hereby agree to personally cooperate with, and take all steps necessary, required or reasonably requested by, any Health Coverage, to effectuate, perfect, confirm or validate my assignment and/or authorization of ARS as my authorized representative, and I promise to assist and cooperate with Providers and ARS as needed or reasonably requested by Providers or ARS in connection with any action in any forum, whether legal, formal or informal, without limitation, commenced or maintained by Providers or ARS in connection with the Services or relating to any Rights provided under the Health Coverage. I understand that, in the event I do not fulfill any of the above obligations, I will remain personally liable for payment for the Services to the furthest extent of the law.

By signing below, I acknowledge my authorization of treatment and receipt of all documentation in accordance with my treatment.

_____ _____

Signature of Beneficiary/Participant/Parent/Legal Guardian Date

_____

Printed Name of Beneficiary/ Participant/Parent/Legal Guardian

AUTHORIZED REPRESENTATIVE SERVICE AGREEMENT

WHEREAS, You, _____ the Patient/Beneficiary (or the parent/legal guardian of the Patient/Beneficiary) have received or may receive healthcare services and/or products from Provincial Park Surgery Center, LLC (collectively the "Providers") which have been or may be under-reimbursed or denied by your group health plan (the "Unpaid Claims").

WHEREAS, Advanced Reimbursement Solutions, LLC ("ARS") has agreed to help Providers collect Unpaid Claims.

WHEREAS, Unpaid Claims may result in You owing money to Providers and your cooperation with Providers and ARS to resolve Unpaid Claims may reduce the amount owed.

WHEREAS, You are hereby informed that you may appoint ARS to pursue payment of the Unpaid Claims on your behalf as your authorized representative.

By signing below, the parties agree as follows:

1. **APPOINTMENT**. You agree to appoint ARS to serve as your ERISA authorized representative using the attached *Authorization of Representative Relating to Healthcare Benefits*. If your group health plan requires a different form to appoint ARS to serve as your ERISA authorized representative, You agree to complete such form and provide it to ARS as soon as reasonably possible after you are notified such a form is required. You understand that during the course of ARS's representation of You, ARS may contact your Insurance Company and/or your employer-sponsored health plan's plan administrator.

2. **SERVICES AND TERM**. ARS will pursue Unpaid Claims by appealing said Unpaid Claims on your behalf until paid in full or the ERISA claims or appeal process is exhausted, whichever occurs first.

3. **COOPERATION**. You agree to cooperate with ARS in pursuing claims and appeals on your behalf. This cooperation includes, for example, completing and signing additional forms such as an *Authorization for Use and Disclosure of Protected Health Information* form allowing ARS to obtain protected health information from your group health plan. Additionally, you agree to forward any payments that you receive to Providers. If You fail to cooperate, ARS will notify Providers. Your failure to cooperate may cause amounts you owe to Providers to become immediately due and payable.

4. **REVOCATION**. You understand that you may revoke ARS's ability to act as your authorized representative. If You do so before your Unpaid Claims are paid in full, or the ERISA claims and appeal process is exhausted, ARS will notify Providers of the revocation. Your revocation may cause amounts you owe to Providers to become immediately due and payable.

5. **TERMINATION**. This Agreement may be terminated by either party at any time for any reason, upon thirty (30) days' written notice to the other party. If You terminate this Agreement, ARS will notify Providers. Termination of this Agreement may cause amounts you owe to Providers to become immediately due and payable.

"ARS"

Advanced Reimbursement Solutions, LLC

By: Gregory Brian Mayon Maldonado

President, ARS

"You"

Print name: _____

Sign name: _____

Date: _____

Election for “Out of Network Benefits”

To Whom It May Concern:

I understand that I have paid for a health insurance plan that includes out-of-network benefits. This letter will serve as official notification that I have elected to utilize my out-of-network benefits as outlined in my health insurance plan and that I understand the implications of that election.

I understand that the hospitals/Providers I have selected, Provincial Park Surgery Center, LLC (collectively the “Providers”) are not participating in my health insurance plan’s network.

I understand that the benefits I receive from my health insurance plan for the services provided by the Providers I have selected will be out-of-network benefits which are different than in-network benefits.

Should this election be prohibited in part or in whole under any provision of my policy/plan, please advise and disclose in writing, within 30 days upon receipt of my election, to my Providers and to me the specific Plan provision that prohibits me from electing out-of-network benefits; otherwise this election should be reasonably expected to be effective.

Additionally, if you do not wish to approve my claim as submitted, please promptly provide necessary claim forms, instructions, reasonable assistance and documents including the Summary Plan Description, that were relied upon to make the decision so that I can comply with the policy conditions and the insurer's reasonable requirements.

Sincerely yours,

_____ _____

Signature **Date**

_____

Print Name

Authorization for Use and Disclosure of Protected Health Information (PHI)

Authorizing Party

Patient Name: _____ Telephone #: _____

Name of Parent/Legal Guardian (If Applicable) _____

Address: _____ City: _____ State: _____ Zip: _____

Group #: _____ Identification/ Subscriber #: _____

Disclosing Party
Insurance Carrier: _____

Authorized Party to Receive PHI
Advanced Reimbursement Solutions, LLC (ARS)
2801 Centerville Road, First Floor, PMB #550, Wilmington, DE 19808
(602) 773-1478

PHI Authorized for Release
I authorize the release of the following PHI with dates of services within one year of the date of execution of this release ("Service Period") or, if specified here, from _____ to _____ ("Dates of Service"):

- Health Plan Benefits and Coverage;
- Billing and Payment;
- Claims and Appeals (including entire Claim File);
- Service Determination Information;
- Eligibility and Enrollment;
- Treatment Approvals (Pre-certification and Pre-authorization), and
- Medical Records

But not PHI regarding: HIV/AIDS, sexually transmitted illness, genetic testing, alcohol/substance abuse, or mental health.

Expiration
This authorization will expire after claims within the Service Period or listed Dates of Service are fully adjudicated or litigated as permitted under state and federal law or upon revocation as described below.

Approving Authorization
I, the Authorizing Party, authorize the Disclosing Party to disclose my protected health information as described in this document at the request of ARS. I understand that ARS is not a health plan or health care provider and the disclosed information may no longer be protected by federal and state privacy regulations. The information may be disclosed to Guardian Healthcare Law Group PLLC (Phoenix, AZ) or another third-party law firm for purposes of appeal or communicating with the plan administrator.

I understand that I may revoke this authorization at any time by giving written notice to ARS and the Disclosing Party. I understand that revocation of this authorization will not affect any action the Disclosing Party took in reliance on this authorization before the Disclosing Party received my written notice of revocation.

I understand that this authorization is voluntary and that the health plan cannot condition my eligibility for benefits, treatment, enrollment or payment of claims on the signing of this authorization. I understand that upon request I can receive a copy of this form. If the Disclosing Party requires a different form to authorize release of my PHI, please send that form along with the plan documents requiring that form to ARS at the address listed above.

I certify that the information above is true and correct to the best of my knowledge.

_____ _____

Signature of Authorizing Party / Parent / Legal Guardian Date

FAN CLIENT CHECKLIST FOR ARS & CLAIMS PROCESSING

☐ PATIENT DEMOGRAPHICS

Patient First & Last Name[1]
Patient Address
Telephone Number
Date of Birth
Gender
Email Address
Copy of ID card

☐ INSURANCE INFORMATION FROM SUBSCRIBER (by checking box, client is confirming that all information is included; if optional item does not apply to this patient, cross through the item)

Legible Copy of Health Insurance Card
Name of Insurance Company
Subscriber Full Name[2]
Subscriber Date of Birth
Relationship to Patient
Insurance ID Number
Group Number
Group Name
Name of Sponsoring Employer[3]
Address of Sponsoring Employer[4]
Insurance Phone #
Claims Mailing Address
Prior Authorization number (if obtained)

☐ BILLING INFORMATION (by checking box, client is confirming that all information is included; if optional item does not apply to this patient, cross through the item)

Date of Service
Attending/Operating Physician
Referring Provider
Physician/Surgeon Assistant
Price for any Supply Codes
Place of Service
Operative Report and/or Office Notes
Invoice for Implant Codes at ARS Charge Rate
FOR ANESTHESIA FILES: Include Anesthesia Record
FOR PAIN FILES: include History & Physical

☐ CODING INFORMATION, If necessary (by checking box, client is confirming that all information is included; if optional item does not apply to this patient, cross through the item)

Diagnosis Codes
Units for all CPT/HCPCS Codes
Revenue Codes for all CPT/HCPCS codes
CPT/HCPCS Codes to be Billed
Modifiers Associated with CPT/HCPCS Codes

☐ ARS DOCUMENTS (all forms must be legibly completed, dated and signed by the patient)

- AOR/POA: Authorization of Representation and Specific Power of Attorney
- OON: Out of Network Election
- PHI: Disclosure of Protect Health Information
- AOB: Assignment of Benefits
- ARSA: Authorized Representative Service Agreement

By submitting the claim to ARS I understand that all of the above information is required for acceptance and processing. I further understand that all information must be legible and accurate.

Date Submitted: _____ Packet Submitted by (write name): _____

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[1] Patient is the person having the procedure

[2] Subscriber is the name of the person who carriers the insurance

[3] Subscriber Employer: is the name of the employer of the person who carriers the insurance

[4] Address of the Subscriber Employer: is the mailing address where the subscriber works