

**University Pain Medicine Center**  
**Didier Demesmin, M.D.**

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**Conditional Assignment of Benefits**

**Policy Number:** \_\_\_\_\_

**Claim Number:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**Medical Provider's Name:** \_\_\_\_\_

I authorize and request \_\_\_\_\_ Insurance Company to pay directly to the above named medical provider, the amount due me under the terms of the above referenced policy as a result of medical care rendered by that medical provider and all medical staff associated with the providers office.

Date \_\_\_\_\_  
\_\_\_\_\_ Patient's Signature or Legal Parent / Guardian

I have read the information contained in the \_\_\_\_\_ Insurance Company informational letter concerning the pre-certification plan, including Medical Services Review, Decision Point Review and pre-certification requirements and, as a condition precedent to \_\_\_\_\_ Insurance company's acceptance of this assignment, I agree for myself on behalf of all medical staff associated with my office, to the following:

- 1) I (we) have complied and will comply with all the procedures of the Pre-certification Plan: and,
- 2) In the event that I (we) fail to comply with all of the requirements of the Plan, and such failure results in the imposition of a co-payment penalty, I (we) will hold the patient harmless for such co-payment penalty insofar as I (we) will not seek payment from the patient for any unpaid portion of the medical services arising from such co-payment penalty.
- 3) In the event that my account is taken to collections I will be responsible for any court/attorney fees.

I (we) understand that \_\_\_\_\_ Insurance Company has the right to reject this assignment of benefits.

Date \_\_\_\_\_  
\_\_\_\_\_ Provider Signature