Lotus Anesthesia, LLC

For questions about your Anesthesia Charges, please call
1-800-208-6014

Dear Patient:

Thank you for allowing **Lotus Anesthesia, LLC** to provide the highest level of comprehensive anesthesia services for you. This letter is intended to inform you of our billing practices for the services you have received. There are multiple billing components, such as the professional services of the surgeon, the professional services of the anesthetist, professional services of the pathologist, drugs/supplies, and the use of the facility and equipment.

Billing: As a courtesy, we will bill your primary and/or secondary insurance company for your anesthesia services and make every effort to collect all charges from your insurance company. However, if your insurance company deems the anesthesia charge or the services of the anesthetist as non covered, you will billed at our current self pay rate.

- If we are **in network** with your insurance company, we will receive the payment and EOB directly from the insurance company. You will be responsible for paying any co-pays and deductibles in accordance with your insurance carrier contract.

- If we are **out of network** with your insurance carrier, the payment and EOB (Explanation of Benefits) for our services may be sent to you. You will need to endorse the insurance payment check and mail it, along with the EOB to the address listed below. You will receive a mailing from our billing company with specific instructions. As a non-participating provider, we are unable to determine the payment your carrier will make, thus we are unable to accurately determine what, if any, you will be responsible for. Once we receive the EOB, we will be able to make that determination. Lotus Anesthesia, LLC will make every effort to collect all payment directly from your insurance company.

- Patients with **no** insurance coverage will be billed at the current self pay rate. If you wish to pay for services and not submit a claim to your insurance carrier, please contact our office to discuss payment. Generally, you will be responsible for the amount the carrier would have paid if the claim had been filed. If you are deemed indigent by your State Authority, please provide a copy of the letter to our office.

If you have any questions concerning your bill, please contact our billing office, toll free at:

1-800-208-6014

Please mail payments, EOB (Explanation of Benefits), correspondence, etc to:

Billing Services
Ref: Lotus Anesthesia
P.O. Box 529
Watkinsville, GA 30677

Larkins Printing
(706) 543-9871
Form #100

LOTUS ANESTHESIA, LLC
PO BOX 529
Watkinsville, GA 30677

PHONE # **800-208-6014**

FAX # 706-850-7733

PROCEDURE LOCATION: Digestive Care Endoscopy

RE: **Authorization to appeal claim**

Dear Patient:

In the event that your insurance company does not process your claim for anesthesia services correctly, you have the right to choose an authorized representative to assist you with an appeal. Thus, we are asking you to appoint Lotus Anesthesia, LLC as your authorized representative to appeal your claim on your behalf if such an appeal becomes necessary. Due to the passage of the Affordable Care Act, Lotus Anesthesia, LLC can no longer file an appeal with your insurance company without this authorization.

As your authorized representative, we will have your permission to discuss your anesthesia claim with your insurance carrier, determine the appropriate basis for an appeal, and act for you on matters relating to your appeal, including obtaining information about your claim and sending appeal request letters on your behalf. All communications about your appeal will come to us as we attempt to resolve all appeals as quickly as possible.

Therefore, we ask that you please sign the attached form at your convenience. We are hopeful that we may never have to appeal a claim for you and that your insurance carrier will process your anesthesia claim correctly. However, in the off chance that your carrier does not process your claim correctly, we will keep the attached form on file, so we do not have to involve you with the appeal process at a later date.

If you have any questions or concerns regarding this form please feel free to contact us at 800-208-6014 Monday through Friday from 9:00 am to 4:30 pm EST. Thank you for allowing us to partner with you to maximize your insurance benefits under your health insurance policy.

Sincerely,

Billing Representative

Lotus Anesthesia, LLC • Assignment of Benefits/Rights Form

I ______________________________ The undersigned (the "Patient"), having healthcare benefit coverage through a group (including a self-funded and employer/employee benefit plan), Medicare, Medicaid and/or individual healthcare plan (collectively, the "Plan"), hereby assigns and conveys directly to **Lotus Anesthesia, LLC** (the "Provider"), the right to pursue payment for all eligible benefits under my plan or policy, including all rights to pursue administrative appeals, all remedies and all causes of action wholly in my stead, to receive all benefits entitled and otherwise payable for medical services, treatments, therapies, and/or medications rendered or provided by the Provider under the Plan, regardless of the Provider's managed care network participation status. The Patient hereby appoints the Provider, **Lotus Anesthesia, LLC** and/or the Provider's appointed business associates, the Patient's rights, title, and interests in and to, and related to the recovery of, any and all benefits which the Patient is entitled to receive under the Plan or insurance policy and authorizes the Provider to release all medical information necessary to pursue and process the Patient's benefits and claims thereunder.

I certify that the health insurance information that I provided is accurate and that I am responsible for keeping it updated. I hereby authorize provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator). I also hereby instruct my benefit plan (or its administrator) to pay the Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and the provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make the check payable to me and mail it directly to the provider. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for all professional services from the Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles. I understand, agree and hereby certify that I am obligated to pay, as charged and billed for global service charges, regardless if the above services are covered under my health insurance or plan. I understand that "Deductible" is defined, under the Uniform Glossary from ERISA & the Patient Protection & Affordable Care Act (ACA) as: "The amount you owe for healthcare services your health insurance or plan covers before your health insurance or plan begins to pay," and that I have no knowledge of any plan exclusion or limitation for the charges for healthcare services rendered by the above listed provider, in case that I can't afford to pay for 100% deductible. I understand the payments are due at the time of the services unless otherwise applicable to any PPO or ACA discount once my claim for benefits is processed in full compliance with plan terms and governing laws. I understand I am fully protected against any unexpected medical bills or charges by my provider's applicable ACA or indigency discount policy; including any non-compliant, ambiguous, or arbitrary and capricious PPO Discounts or Re-pricing Discounts received from my health insurance plan. My satisfaction is guaranteed in connection with my provider's proactive reasonable efforts to collect or make a good faith determination for ACA Discount qualifications solely based on my unique ability to pay and individual health need. I hereby assign billed charges for healthcare services rendered as my legal claims to the above listed provider as full payment, as my authorized representative and an ERISA or ACA claimant, to claim or legally pursue proper payment of benefits from my health insurance or plan.

This authorization includes all rights applicable under federal and state regulations to give the provider and its attorneys standing to pursue payment, appeals and file suit for benefits and any fiduciary breach and all causes of action under ERISA and Section 502, 27 § U.S.C. 1132(a)., as well as any social security act or all rights governed under the Affordable Care Act to **Lotus Anesthesia, LLC**. I hereby authorize the Provider, **Lotus Anesthesia, LLC**, its attorneys or other designated business associate to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; (3) To file and participate in any administrative or judicial review process; (4) to give the provider and its attorneys standing to pursue payment, appeals and file suit for benefits, any fiduciary breach and all causes of action under ERISA and Section 502, 27 § U.S.C. 1132(a). (5) to pursue all necessary action and rights to available administrative appeals and remedies, wholly in my stead; (6) to pursue a claim for benefits and to recover penalties for failure by my plan or its claims administrator to comply with 29 USC § 1132 and (7) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing. I authorize Provider or **Lotus Anesthesia, LLC**, its designated business associate to make any request, file and obtain appeals information, receive any notice in connection with my healthcare services, benefits, appeal, required legal action or other rights, wholly in my stead. Further, I hereby authorize my plan administrator, fiduciary, insurer, and/or attorney to release to the above-named health care provider or its designated business associated any and all relevant Plan and claim documents, requested disclosures, complete insurance policy, and/or settlement information upon written request from the provider, its attorneys or designated business associates in order to secure and claim such medical benefits. I authorize the release or disclosure of my protected health information to my authorized representative in order to secure and claim medical benefits due; (1) obtain information or submit evidence regarding the claim to the same extent as me; (2) make statements about facts or law; (3) act as my authorized representative in connection with filing, providing or receiving notice of any claim or appeal proceedings, to include any external review by applicable state or Federal External Review Process. I authorize my designated authorized representative to make any request; to present or to produce evidence; to file and obtain any claim, appeal or external review information; to receive any notice in connection with my claim, appeal or external review; wholly in my stead. I understand that I will be held financially responsible for all fees accumulated for collection agency fees. Administrative fees, attorney fees and court costs incurred by the provider listed above for any delinquent account requiring outside collection assistance, to the fullest extent of the law. I understand revocation of this appointment will not affect any action taken in reliance on this appointment before my written notice of revocation is received. Unless revoked in writing, this assignment is valid for any and all requested administrative and judicial reviews rightfully due me under my governing plan or policy and to the fullest extent permitted by law. A photocopy of this assignment is to be considered valid, the same as if it was the original. I understand that, by signing this form, I am confirming my appointment of my authorized representative, the scope of my authorized representative's authority, and the option of revoking of this appointment. I have read and acknowledged this agreement.

______________________________	______________________________	____________
Patient/Guardian/Insured Signature	Witness	Date