Pain Treatment with Opioid Medications: Patient Agreement

This Agreement is essential to the trust and confidence necessary in a prescriber/patient relationship. My prescriber has discussed my treatment plan with me. I understand that there is a risk of psychological and/or physical dependence and addiction associated with the chronic use of controlled substances for pain. I have been told about the side effects that I may experience. My prescriber is undertaking to treat me with controlled substances for pain because:

I, _____ , understand and voluntarily agree to the following (initial each statement after reviewing):

☐ I have told my prescriber about other medications I am taking and my medical history, including my prior experience with pain medications or other drugs. Throughout my treatment, I will communicate fully with my prescriber about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medication is helping to relieve pain.

☐ I will take my medication, _____ , as instructed and not change the way I take it without first talking to my prescriber or other members of the treatment team. I understand that my prescriber may change this medication during my course of treatment.

☐ I will not attempt to obtain pain medications from any other prescribers and understand that my prescriptions will be issued only during scheduled office visits with the treatment team or during regular office hours. If I require surgery or emergency treatment, and I am able to communicate, I will tell the health care professional taking care of me about all the medications I am taking and, at or before my next refill, I will tell my prescriber about my use of medications in these circumstances.

☐ I agree not to use illegal drugs or alcohol while on these medications.

☐ I understand that I should not drive a motor vehicle or operate machinery if the medication causes dizziness, drowsiness, or sedation.

☐ I will use one pharmacy to get all my medications: _____
Pharmacy Name/Phone Number

☐ I understand that I may be referred to other health care professionals for other modes of treatment, such as physical therapy, exercise, relaxation techniques or psychological counseling, or for certain diagnostic tests and that my prescriber may speak with other health care professionals about my treatment plan. At this time my treatment plan includes: _____.

☐ I will keep the medicine safe, secure, and out of reach of others, and will dispose of unused medications in a Project Medicine Drop Box, through a Take-back Program or in a drug disposal pouch.

☐ I will not sell this medicine or share it with others. If my medicine or prescription is lost or stolen, I understand that it may not be replaced.

☐ I understand that I may need to submit to random urine drug testing and pill counts if requested by my prescriber and that my prescriber will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program web site.

☐ I understand that if I do not follow all of the terms of this Agreement, my prescriber may stop prescribing pain medications, and/or that I could be required to find another prescriber or health care professional for my future medical treatment.

_____	_____	_____
Patient Signature	Patient Name Printed	Date
_____	_____	_____
Prescriber Signature	Prescriber Name Printed	Date

NOTE: Some agreements include the actual side effects that a patient may experience. Other provisions may be included, but are not required, such as:

☐ I will keep all of my scheduled appointments including appointments for refills. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.

☐ I will not call between appointments, or at night or on the weekends looking for refills. I understand that prescriptions will be filled only during scheduled office visits with the treatment team or during regular office hours.

JERSEY REHAB PA
PAIN MANAGEMENT

Edwin M. Gangemi, M.D. **Shailendra Hajela, M.D.**
Robert A. Marini, M.D. **Felix A. Almentero, M.D.**
www.jerseyrehab.com

WAIVER

I, _____ understand that my insurance company may not cover
(Print patient's name)

certain procedures and supplies that are necessary for my treatment. I understand that I am responsible for charges that I incur during my treatment(s) which are not covered by my insurance company.

I will make payments if necessary as discussed and agreed upon with Jersey Rehab, P.A.

Date: _____

Name: _____ (print)

_____ (Signature) _____ (Initial)

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RECORDS / FILMS RELEASE FORM

To: Jersey Rehab, P.A.

I, _____ hereby request that records/films be released to myself.
I will take responsibility for the records/films that I received from Jersey Rehab, P.A.

_____ _____
(Date of Request) (Patient's signature)

_____ _____
(Witness) (Address)

_____ _____
(Date) (City, State, Zip Code)

Edwin M. Gangemi, M.D. **Shailendra Hajela, M.D.**
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NO SHOW POLICY

Patients who schedule appointments but fail to show up are documented as "No-Shows".

A 24-hour advanced notice of cancellation of an appointment is required by our office.

Failure to do so will result in a $25.00 charge, and this charge is not covered by your insurance company.

Please be courteous to your provider and fellow patients. If you are unable to attend your appointment, please cancel your appointment as soon as possible.

Signature: _____ Date: _____

Print Name: _____ DOB #: _____

Witnessed by: _____ Date: _____

{00188352.1 / NJ / FORMS}

JERSEY REHAB PA
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PHYSICIAN PRACTICE'S NOTICE OF PRIVACY

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU HAVE BE USED AND DISCLOSED AN HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).
We are legally required to protect the privacy of your health information. We call this information "protected health information" or "PHI" for short, and it includes information that can be used to identify you that we've created or received about your past, present or future health care. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

However, we reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and post a new notice in Jersey Rehab's reception area. You can also request a copy of this notice from the contact person listed in Section IV below at any time and can view a copy of this notice on our Web site at www.jerseyrehab.com.

III. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.
We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your specific authorization. Below, we describe the different categories of uses and disclosures.

1. Uses and Disclosures, Which Do Not Require Your Authorization.

We may use and disclose your PHI without your authorization for the following reasons:

a. For treatment. We may disclose your PHI to hospitals, physicians, nurses, and other health care personnel who provide you with health care services or are involved in your care. For example, if you're being treated for a knee injury, we may disclose your PHI to an x-ray technician in order to coordinate your care.

b. When a disclosure is required by federal, state or local law, judicial or administrative proceedings or law enforcement. For example, we made disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot or other wounds; or when ordered in a judicial or administrative proceeding.

c. For public health activities. For example, we report information about births, deaths, and various diseases, to government officials in charge of collecting that information, and we provide coroners, medical examiners, and funeral directors necessary information relating to an individual's death.

d. For health oversight activities. For example, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.

e. For purposes of organ donation. We may notify organ procurement organizations to assist them in organ, eye, or tissue donation and transplants.

f. For research purposes. In certain circumstances, we may provide PHI in order to conduct medical research.

g. To avoid harm. In order to avoid harm, a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

h. For specific government functions. We may disclose PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes, such as protecting the president of the United States or conducting intelligence operations.

i. For worker's compensation purposes. We may provide PHI in order to comply with worker's compensation laws.

j. Appointment reminders and health-related benefits or services. We may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer.

B. Use and Disclosure Where You Have the opportunity to Object:

1. Disclosures to family, friends or others. We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part.

C. All Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described above, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we haven't taken any action relying on the authorization).

D. Incidental Uses and Disclosures. Incidental uses and disclosures of information may occur. An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure. However, such incidental uses or disclosures are permitted only to the extent that we have applied reasonable safeguards and do not disclose any more of your PHI than is necessary to accomplish the permitted use or disclosure. For example, disclosures about a patient at a nursing station that might be overheard by personnel not involved in the patient's care would be permitted.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI.

You have the following rights with respect to your PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide you them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

2. The Right to Choose How We Send PHI to You. You have the right to ask that we send information to your to an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested.

3. The Right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.

   If you request copies of your PHI, we will charge you $1.00 for each page. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

4. The Right to Get a List of the Disclosures We Have Made. You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, to your family, or in our facility directory. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or before Jersey Rehab's HIPAA compliance date.

   We will respond within 60 days of receiving your request. The list we will give you will include disclosures make in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to your at no charge, but if you make more than one request in the same year, we will charge you $1.00 for each page.

5. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. We will respond within 60 days of receiving your request in writing. You must provide the request and your reason for the request in writing. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

6. The Right to Get This Notice by E-Mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a compliant with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Ave., S.W.; Room 615F; Washington, DC 20201. We will take no retaliatory action against you if you file a complaint about our privacy practices.

VI. PERSONS TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact our HIPAA Privacy Officer, Laura Blake-Gangemi at 973-783-5538.

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on _____.

I acknowledge receipt of Jersey Rehab's Provider's Notice of Privacy Practices:

Print Name: _____

Signature: _____

Date: _____

JERSEY REHAB PA
PAIN MANAGEMENT

Edwin M. Gangemi, M.D. Melissa Gallagher , PAC.
Robert A. Marini, M.D. Felix A. Almentero, M.D.
Shailendra Hajela, M.D.

IF THIS IS DUE TO A MOTOR VEHICLE ACCIDENT PLEASE BRING IN THE FOLLOWING

1. COPY OF MOTOR VEHICLE INSURANCE CARD
2. POLICE REPORT
3. DECLARATION PAGE FROM YOUR POLICY BOOK
4. POLICY NUMBER
5. CLAIM NUMBER
6. DATE OF MOTOR VEHICLE ACCIDENT
7. ADJUSTER NAME, PHONE NUMBER, FAX, AND ADDRESS
8. ATTORNEY NAME, PHONE NUMBER, FAX AND ADDRESS

IF THIS IS DUE TO WORKERS COMPENSATION ACCIDENT PLEASE BRING IN THE FOLLOWING

1. CLAIM NUMBER
2. DATE OF INJURY
3. INSURANCE NAME, PHONE NUMBER, FAX, AND ADDRESS
4. ADJUSTER NAME, PHONE NUMBER, FAX
5. ATTORNEY NAME, PHONE NUMBER, FAX AND ADDRESS
6. EMPLOYER NAME, PHONE NUMBER, FAX AND ADDRESS

THANK YOU

Edwin M. Gangemi, M.D. **Shailendra Hajela, M.D.**
Robert A. Marini, M.D. **Felix A. Almentero, M.D.**
www.jerseyrehab.com

ACCIDENT INSURANCE INFORMATION

TYPE OF ACCIDENT: MOTOR VEHICLE ____ WORKMEN'S COMPENSATION ____ LIABILITY ____
DATE OF ACCIDENT: _____ DO YOU HAVE AUTO INSURANCE? YES / NO
NAME OF INSURANCE COMPANY: _____
INSURANCE COMPANY ADDRESS: _____
POLICY #: _____ CLAIM #: _____
CLAIM REPRESENTATIVE: _____
WERE YOU THE DRIVER? ____ PASSENGER? ____ PEDESTRIAN? ____ OTHER _____
BRIEF DESCRIPTION OF ACCIDENT _____
_____

HAS THIS ACCIDENT BEEN REPORTED TO YOUR INSURANCE COMPANY? YES / NO
IF NOT, YOU MUST REPORT THE ACCIDENT TO YOUR INSURANCE COMPANY TO PROTECT YOUR BENEFITS, EVEN IF YOU WERE NOT AT FAULT.

IF YOU WERE THE PASSENGER IN A VEHICLE NOT OWNED BY YOURSELF WE WILL NEED THE FOLLOWING INFORMATION:
VEHICLE OWNER: _____ INSURANCE COMPANY: _____
POLICY #: _____ CLAIM #: _____
DOES ANYONE ELSE IN YOUR HOUSEHOLD HAVE AUTO INSURANCE OF THEIR OWN? YES / NO
NAME: _____ RELATIONSHIP: _____
INSURANCE CO: _____ POLICY #: _____

****

WORKMEN'S COMPENSATION INFORMATION: DATE OF ACCIDENT: _____
AUTHORIZED FOR TREATMENT: _____ UNAUTHORIZED FOR TREATMENT: _____
EMPLOYER'S NAME: _____
WORKMEN'S COMPENSATION CARRIER: _____
WORKMEN'S COMPENSATION CARRIER ADDRESS: _____
CITY _____ STATE _____ ZIP CODE _____ TEL # ( ) _____
CLAIM REPRESENTATIVE _____ OR CONTACT PERSON _____

****

ARE YOU REPRESENTED BY AN ATTORNEY FOR THIS INJURY? ( ) YES ( ) NO
ATTORNEY NAME: _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
TELEPHONE # ( ) _____ PARALEGAL OR SECRETARY NAME _____

APPLICATION FOR BENEFITS—PERSONAL INJURY PROTECTION

IMPORTANT:
1. TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PERSONAL INJURY PROTECTION LAW, YOU MUST COMPLETE AND SIGN THIS FORM.
2. YOU MUST ALSO SIGN THE ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE NUMBER

TO: CURE
CLAIM DEPT.
214 CARNEGIE CENTER, SUITE 101
PRINCETON, NJ 08540

YOUR NAME	PHONE NO. HOME	BUSINESS
YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE)	DATE OF BIRTH / /	SOCIAL SECURITY NO.

DATE AND TIME OF ACCIDENT / / A.M. P.M.	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)
BRIEF DESCRIPTION OF ACCIDENT	

WERE YOU THE DRIVER OF THE AUTOMOBILE? YES ☐ NO ☐ WERE YOU A PEDESTRIAN? YES ☐ NO ☐
WERE YOU A PASSENGER IN THE AUTOMOBILE? YES ☐ NO ☐ WERE YOU A MEMBER OF THE AUTOMOBILE OWNER'S HOUSEHOLD? YES ☐ NO ☐

DO YOU OR ANY MEMBER OF YOUR HOUSEHOLD OWN AN AUTOMOBILE? YES ☐ NO ☐

DESCRIBE ALL AUTOMOBILES OWNED BY YOU OR ANY MEMBER OF YOUR FAMILY THAT RESIDED IN YOUR HOUSEHOLD AS OF THE DATE OF THE LOSS.

AUTOMOBILE	OWNER	INSURANCE CO.	POLICY NUMBER

DID YOU HAVE HEALTH INSURANCE ON THE DATE OF LOSS? YES ☐ NO ☐
IF YES, PROVIDE THE INFORMATION REQUESTED BELOW REGARDING YOUR HEALTH INSURER(S):

1. NAME: _____
ADDRESS: _____
PHONE: _____
FAX#: _____
E-MAIL: _____
POLICY/GROUP #/CERTIFICATE #: _____

2. NAME: _____
ADDRESS: _____
PHONE: _____
FAX#: _____
E-MAIL: _____
POLICY/GROUP#/CERTIFICATE #: _____

WERE YOU INJURED AS A RESULT OF THIS ACCIDENT? YES ☐ NO ☐ IF YOUR ANSWER IS **YES**, COMPLETE THE REST OF THIS FORM. IF **NO**, SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: _____ DATE: _____

DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCTOR? YES ☐ NO ☐	DOCTOR'S NAME AND ADDRESS
IF YOU WERE TREATED IN A HOSPITAL WERE YOU AN IN-PATIENT? ☐ OUT-PATIENT? ☐	HOSPITAL'S NAME AND ADDRESS

AMOUNT OF MEDICAL BILLS TO DATE: $	WILL YOU HAVE MORE MEDICAL EXPENSE? YES ☐ NO ☐	AT TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES ☐ NO ☐
DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY? YES ☐ NO ☐	IF YES, AMOUNT LOST TO DATE $	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? $

IF YOU LOST WAGES: DATE DISABILITY FROM WORK BEGAN _____ DATE YOU RETURNED TO WORK _____

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR BENEFITS UNDER

	YES	NO
(1) ANY WORKMEN'S COMPENSATION LAW?	☐	☐
(2) EMPLOYEES TEMPORARY DISABILITY BENEFIT STATUTE?	☐	☐
(3) MEDICARE?	☐	☐

IF YES, AMOUNT $ _____ ☐ PER WEEK ☐ PER MONTH

LIST NAMES AND ADDRESSES OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? YES ☐ NO ☐ IF YES, EXPLAIN ON REVERSE SIDE.

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

SIGNATURE: _____ DATE: _____

A 3965A (1-95)

AUTHORIZATION FOR MEDICAL INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAY AND PHYSICAL FINDINGS DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE PERSONAL INJURY PROTECTION BENEFITS LAW.

SIGNATURE: _____ DATE:

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES OR SALARY WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE PERSONAL INJURY PROTECTION BENEFITS LAW.

SIGNATURE: _____ DATE:

AUTHORIZATION TO EXTEND TIME TO SCHEDULE A PHYSICAL EXAMINATION FOR DECISION POINT REVIEW
(OPTIONAL)

TO ASSURE MY ABILITY TO ATTEND THE REQUIRED PHYSICAL EXAMINATION, I HEREBY AUTHORIZE CURE TO TAKE UP TO 14 DAYS AFTER RECEIPT OF NOTICE FROM MY HEALTH CARE PROVIDER (RATHER THAN THE 7 DAYS NORMALLY REQUIRED) FOR SCHEDULING A PHYSICAL EXAMINATION IF ONE IS NEEDED IN ORDER TO MAKE A DETERMINATION REGARDING THE MEDICAL NECESSITY OF TESTS OR TREATMENTS UNDER THE CURE DECISION POINT REVIEW PLAN.

SIGNATURE: _____ DATE:

JERSEY REHAB PA
PAIN MANAGEMENT

Edwin M. Gangemi, M.D. Shailendra Hajela, M.D.
Robert A. Marini, M.D. Felix A. Almentero, M.D.
www.jerseyrehab.com

ATTORNEY RELEASE FORM

ATTORNEY NAME: _____

ATTORNEY ADDRESS: _____

_____

_____

RE: _____

D/A: _____

I authorize Jersey Rehab, P.A. to release my medical records and any other necessary information to the above-mentioned attorney.

Date: _____ **Patient signature:** _____

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

☐ 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.

☐ 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)

* 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.