NEW YORK STATE DEPARTMENT OF HEALTH
UNINSURED CARE PROGRAMS
Empire Station, PO BOX 2052
Albany, NY 12220-0052

Assignment of Benefits

Name _____ ADAP ID 555 - _____ - _____ - _____
(First) (M.I.) (Last)

Address _____
(c/o) (Street) (Apt. #)

City _____ State New York Zip Code _____ - _____

Date of Birth ___ / ___ / _____ Social Security Number XXX - XX - _____
(mo.) (day) (year)

Home Phone (___) ___ - _____ Work Phone (___) ___ - _____ _____
(ext.)

EMPLOYER* _____
(c/o) (Address)

*Under NY State law, information regarding the nature of your illness cannot be related to an employer without a signed statement by you.

INSURANCE COMPANY INFORMATION

Company Name _____

Billing Address _____
(c/o) (Street) (Apt. #)

City _____ State _____ Zip Code _____ - _____

Individual Policy Number _____ Group Policy Number _____

Pharmacy Benefits Policy Number _____

Coverage Start Date ___ / ___ / _____
(mo.) (day) (year)

Relationship to Policy Holder (CIRCLE ONE)
SELF SPOUSE DEPENDANT OTHER

The Uninsured Care Programs are authorized to provide health related information to my insurance company, and/or its contracted benefits manager and to collect from my insurance company (named above) the total amount due for the benefits delivered to me.

If, for whatever reason, my insurance company or its benefits manager should remit payment directly to me for any medical service or product rendered to me by the Uninsured Care programs I shall promptly endorse the check to Health Research, Inc. and mail to the address above.

I shall promptly notify the Uninsured Care Programs, first by phone and follow-up in writing of any change in my insurance coverage or any change in my address.

This Assignment of Benefits shall remain in effect so long as benefits are paid on my behalf by the NYS Uninsured Care Programs, and I continue health insurance through the above named company. Changes in sub-contracted pharmacy benefits managers made by my health insurance company will not require documentation.

The Uninsured Care Programs' Privacy Notice is available at http://www.nyhealth.gov/health_care/ or by calling 1-800-542-2437.

SIGNATURE _____ DATE _____