RELEASE OF MEDICAL INFORMATION & ASSIGNMENT OF INSURANCE BENEFITS

I ____ ("Patient") have been referred to Ascend Clinical, LLC ("Ascend") by a practitioner for purposes of a **Sars-CoV-2 Antibody Test**. I authorize Ascend to disclose my protected health care information to other health care providers, health plans and regulatory agencies in order to provide testing services, and for obtaining payment for this service.

Assignment of Insurance Benefits

I now assign, transfer and give to Ascend all rights and interest in all benefits payable for the above-named service from any Health Plan or insurance policy under which I am entitled to receive payment for the service ("Benefits"). I also assign, transfer and give to Ascend all rights and interest in any and all causes of action related to payment of Benefits against my Health Plan or any other health plan, insurance company, claim administrator or other person or organization responsible for the determination or payment of Benefits ("Responsible Parties").

Authorized Insurance Representative

In consideration of the service provided to me by Ascend, I now designate Ascend as my authorized representative with respect to payment of Benefits for the above named service. I also grant permission to the Health Plan and any Responsible Parties to discuss or disclose protected health information related to me, as applicable, to Ascend as my Authorized Representative for all purposes related to the payment of, or the failure to pay, Benefits for the service.

Patient Signature: _____________________________ **Date:** ______________

Dialysis Facility: Please fax completed form to: (844) 623-5093.

1. LabCheck MRN: ______________ Clinic Code: ___________
2. Select an ICD Code: Z20.828 Z03.818 U07.1 Other: _______
3. Copy of employee's insurance card (both front and back)

Please Note: Invalid/Incomplete submissions will result in a charge to your facility invoice.