KEY HEALTH

LIEN SOLUTIONS PROGRAM FORM
CONTRACT PROVIDER PROCEDURE REQUEST

PROVIDER INFORMATION: **INSIGHT**
ADDRESS: **INSIGHT ADDRESS**
TELEPHONE: **(XXX) XXX-XXXX**
FAX: **(XXX) XXX-XXXX**

Key to be Lien Holder for: ☐ Professional ☐ Facility ☐ Both

PATIENT INFORMATION

Male ☐ Female ☐ SS#: _____ - _____ - _____

Patient Last Name: _____ First: _____ M.I.: _____ Date of Birth: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: _____ Alternate Number: _____

Date of Injury: _____ Appointment/Procedure Date: _____ Time: _____

PROCEDURE

Type and Body Part

Radiology: MRI _____ contrast: ☐ with ☐ without

CT _____ contrast: ☐ with ☐ without

Other _____

Surgery: Outpatient _____

Inpatient _____

Facility where procedure is to be performed (if known): _____

Pain Management: Procedure _____

Level _____

Consultation: ☐ Ortho ☐ Neuro ☐ Other _____

Other: _____

PRIMARY TREATING PHYSICIAN INFORMATION

Physician (*If different from above Provider*): _____

Street Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____ Contact Name: _____

Physician is treating patient on (check all that apply): ☐ P.I. Lien ☐ Medpay ☐ Health Ins. ☐ Other _____

PERSONAL INJURY ATTORNEY INFORMATION

Attorney Name: _____ Contact Person: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ , Fax: _____

LIABILITY INSURANCE CARRIER INFORMATION

Carrier Name: _____ Claim #: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Telephone: _____

By submitting this procedure request, facility acknowledges responsibility for informing the treating physician that Key Health will be the lien service provider and the provider entity billing for the requested procedure.

Requestor Signature _____ Date: _____

Please complete the above information and fax to: **(877) 539-5436**

5601 Lindero Canyon Road • Suite 220 • Westlake Village, California 91362
Telephone (877) 633-5436 / (877) MED-LIEN
Fax (877) 539-5436 / (877) KEY-LIEN

KEY HEALTH

ASSIGNMENT OF PROCEEDS AND/OR LIEN FOR MEDICAL SERVICES

I. Certification, Authorization and Release in Accordance with HIPAA. Patient and Attorney of Record ("Attorney") certify that the information provided herein is correct and complete. Patient understands that, in accordance with the Health Information Portability and Privacy Act of 1996 ("HIPAA"), Patient's medical information relating to this personal injury case may be shared to manage and expedite Patient's medical treatment. Patient authorizes Patient's Physician, Attorney, and Key Health Medical Services, Inc. ("KHMS") and/or its affiliated medical group, Key Health Medical Group, Inc. ("KHMG") to secure, release, and disclose such medical treatment information with companies and individuals as deemed necessary, and further agrees that examinations, diagnoses, medical treatments, films and reports can be shared with necessary parties involved in Patient's case. Attorney acknowledges that Attorney has obtained a Release of Medical Information from Patient for purposes of communications regarding Patient's medical information and that KHMS/KHMG is covered by said Release.

II. Assignment and/or Lien for Medical Services. Patient and Attorney understand that the medical services, supplies and treatment Patient is receiving as part of the ongoing personal injury claim may be billed as a lien as may be authorized by applicable state law and practice. Patient does not have the financial resources to pay the charges at this time and patient does not have insurance coverage to cover such medical services, whereby such insurance coverage would include, but is not limited to, health insurance, Workers' Compensation, government or other medical insurance coverage. Patient and Attorney understand that they are responsible for informing KHMS/KHMG of any change in financial situation as it relates to medical care and coverage. Patient understands that Patient may seek outside independent counsel on any decision regarding the funding of Patient's medical care or for any questions Patient may have relating thereto. This lien may be signed in parts and have the same force and effect as though executed in one document. A photocopy and/or fax copy of the executed lien shall have the same force and effect as the original.

III. Patient Information.

Attorney Name: _____ Telephone: _____ Fax: _____

Attorney Address: _____ City: _____ State: _____ Zip: _____

Patient Name: _____ Key Account Number: _____

Date of Injury: _____ Physician/Facility: _____

IV. Payment Agreement. Patient authorizes and directs Attorney to pay KHMS/KHMG directly for any billings and fees arising out of the medical services, treatment and care, that have been or may be rendered to Patient by KHMS/KHMG as a result of this incident and by reason of any other bills which Patient may owe KHMS/KHMG. Patient understands that Patient remains personally responsible for KHMS/KHMG's billings and that this obligation is not contingent upon Patient's receiving any settlement for Patient's claim. Patient will notify KHMS/KHMG of any payment received by Patient for medical services from an insurance company or other source. Payments will be forwarded to KHMS/KHMG as requested. Patient further understands and accepts financial responsibility for payment of all accounts with KHMS/KHMG. Patient understands that the legal settlement may pay all, part, or none of Patient's account(s) and that Patient is responsible for complete payment of all account(s). Patient understands that Patient is financially responsible for any amount unpaid by this assignment of proceeds and/or lien, as may be authorized by applicable state law and practice. By signing this document, patient fully understands all provisions set forth in this Agreement.

Patient's Signature: _____ Date: _____

The undersigned Attorney of Record for the above-named Patient, hereby agrees to observe all terms stated herein and agrees to withhold such sum payable to KHMS/KHMG from any settlement, judgment or verdict as may be necessary to adequately protect KHMS/KHMG. Attorney is expressly directed to hold in Attorney's Client Trust Account such sums from any payment, settlements, dispositions, proceeds and/or verdicts received on Patient's behalf as may be required to adequately protect and pay KHMS/KHMG for services arranged on Patient's behalf by KHMS/KHMG. Attorney is further directed to pay from Attorney's Client Trust Account to KHMS/KHMG that amount which is due and owing to KHMS/KHMG for those medical services, examinations, treatments and reports which KHMS/KHMG has had prepared on Patient's behalf. Attorney further agrees that in the event Patient secures other counsel in connection with any action instituted by Patient on account of the injuries for which Patient was treated, Attorney shall inform such new counsel of the Agreement, and secure new counsel's consent thereto.

Attorney's Signature: _____ Date: _____

Please complete and return the original to Key Health at the address below.

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