

To: _____ Automobile Insurance Company
Attention: _____ Claim Representative
Claim Number: _____ Fax () _____ - _____

Written Direction, Assignment of Benefits, Release of Information and Authority to Act on My Behalf for my PIP Benefits

Date of Accident: _____ Today's Date: _____

Dear Sir or Madam:

I _____ (patient) is obtaining medical imaging services today from Neurodiagnostics, Inc, dba Lexington Diagnostic Center (LDC) and was referred for these services because of injuries received in an automobile accident on the date listed above.

As of this date and prior to obtaining these services, I _____ (patient/legal guardian of patient) hereby direct the reparation obligor (the insurance company responsible for the patient's personal injury protection (PIP) benefits), _____ to pay LDC for today's services, pursuant to KRS 304.39-241. I further request that you reserve enough of the PIP medical benefits to pay LDC for today's charges. I direct you to pay this bill before executing any future direction notices from me.

I further direct that you pay this bill within 30 days of receipt as required by law. If payment is delayed, I direct that you pay the legally required 12 or 18% interest directly to LDC. If for any reason you do not pay for these medical services and/or interest due, I give LDC full authority to act as my agent and/or on my behalf in filing a legal claim in the appropriate court and/or filing a complaint with the Kentucky Department of Insurance. I irrevocably assign LDC, its successors and assigns, medical benefits payable to me (or to the patient) from my PIP funds for today's services.

I further direct that you provide to LDC any and all protected medical records relating to my case that will assist LDC in collecting payments from you or evaluating any denials, including but not limited to "Peer Reviews" "Second Opinions" or other external reviews. I also authorize you to provide to LDC my (or the patient's) PIP worksheet detailing payments made on my behalf. Please expect a bill from LDC soon for today's medical services.

I authorize a Facsimile (FAX) of this letter to serve as the original.

Printed name of Patient or Patient's Representative

Signature of Patient or Patient's Representative

Date: _____

Witness

This Letter of Direction Notice has been faxed to the above Addressed Claim Representative at _____ AM/PM on _____ by _____