



Assignment of Benefits: Summary of State Requirements

(as of September 30, 2019)

History: Providers contract with health insurance plans or health maintenance organizations (HMOs) in participatory agreements which often include reduced fees for services for plan subscribers in return for direct payments to providers.

- Plan subscribers who use non-participating providers are reimbursed by the health insurance plan or HMO for the services and are then responsible for remitting the payment to the non-participating provider. As a result, non-participating providers must seek reimbursement from the subscriber.
- Under mandatory assignment of benefits (AOB) requirements and direct payment laws, health insurance plans or HMOs are required to directly reimburse non-participating providers for services rendered to subscribers.
- Twenty-nine states (AL, AK, AR, CA, CO, CT, DE, FL, GA, ID, IL, IN, KY, LA, ME, MD, MA, MS, MO, NV, NH, NJ, OH, RI, SD, TN, TX, VA, and WY) have enacted laws or issued regulations that require health insurance plans or HMOs to accept assignments of benefits or make direct payments to non-participating providers.
- Nine states (CA, DE, MD, MA, MS, MO, NV, NJ, and VA) impose a direct payment requirement for emergency care services.
- Four states (AL, MO, TN, and WY) have assignment laws for pharmacy benefits.
- LA and SD assignment laws only extend to licensed hospitals.
- MO and WY have an assignment law for care in public hospitals, state institutions, or facilities.
- OH has an assignment of benefits law for hospital-based emergency services.
- New York General Counsel Opinion 11-21-2000 declares that nothing in the Insurance law or rule obligates an insurer to honor an assignment of benefits request. However, New York common law may place a duty on the insurer to the assignment of benefits request.

Chart: The following chart summarizes assignment of benefit (AOB) laws enacted to date.

Approaches: Assignment laws may apply generally to all health care professionals or services or may have a narrower focus and only apply to subsets of providers or specific services.

- Twenty-three states (AL, AK, CA, CO, CT, DE, FL, GA, IL, KY, ME, MD, MO, MS, NV, NH, NJ, NC, PA, TN, TX, VA, and WY) have laws that apply to broad categories of health care services or providers.
- Twelve states (AL, AK, CT, ID, FL, ME, NH, NJ, RI, SD, TN, and VA) have laws that are specific for dental care and/or oral surgery benefits.

Assignment of Benefits: Summary of State Requirements

State/ Citation	Applicability	Services and/or Providers Covered	Key Provisions
<p>Alabama <i>Ala. Code §27-1-19</i></p> <p>Effective 1994 Amended 2001</p>	<p>Insurers, not including BCBS Plan or State Administered Health Plan¹</p>	<p>Medical, pharmaceutical, podiatric chiropractic, optometric, DME, home health, and dental</p>	<ul style="list-style-type: none"> • Permits insured or plan beneficiary to assign reimbursement for health or dental care services directly to any provider of those services. Health services include medical, pharmacy, podiatric, chiropractic, optometric, durable medical equipment, and home health care services. • Requires insurers, when authorized, to pay the amount of the claim directly to non-contract health care providers, under the same criteria and payment schedule as paid to contract providers, with any applicable interest. • Establishes liability of an insurer when an insurer pays an insured instead of a provider after the rights of reimbursement have been assigned to the provider. • Permits a provider to take action in the circuit or district courts for recovery of any assignment of benefits that the insurer fails to pay plus interest and a reasonable attorney's fee.
<p>Alaska <i>Alaska Stat. §21.51.120</i></p> <p>Effective 1996 Amended 2006</p>	<p>Individual health policies</p>	<p>Indemnity payments for hospital, nursing, medical, dental indemnities, and surgical services</p>	<ul style="list-style-type: none"> • Requires an insurer, upon written request of the insured, to pay indemnities for hospital, nursing, medical, dental, or surgical services directly to a nonparticipating provider of the services. • Also permits a transfer of the assignment, in accordance with a qualified domestic relations order, to another person who is not the insured. • Allows an insured to revoke an assignment of benefits by giving written notice of the revocation to the insurer and to the provider of

¹ Blue Cross and Blue Shield plans are exempt from this law under the ruling in [Blue Cross and Blue Shield of Alabama, Inc. v. Nielsen, 714 So.2d 293 \(Ala.1998\)](#) because no enabling legislation was enacted which would have explicitly included such plans, which are exempt from certain requirements of other insurers. Further, the court held provisions that applied to employee welfare benefit plans and employer-sponsored health benefit plans were preempted under ERISA.

Assignment of Benefits: Summary of State Requirements

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			<p>the services. Requires that a written notice of revocation given to the insurer certifies that the covered person has given written notice of revocation to the provider of the services. Provides that the revocation of an election of direct payment is not effective until the insurer receives the notice.</p> <ul style="list-style-type: none"> • Requires an insurer, who pays an insured after the insured has assigned payment, to also pay the provider of the services.
<p>Alaska <i>Alaska Stat.</i> §21.54.020</p> <p>Effective 2001 Amended 2011</p>	<p>Group or blanket health policies</p>	<p>Hospital, nursing, medical, dental, and surgical services</p>	<ul style="list-style-type: none"> • Permits the insured to transfer the request for payment directly to a nonparticipating provider of services. Also permits a transfer of the assignment, under a qualified domestic relations order, to another person who is not the insured. • Allows an insured to revoke an assignment of benefits by giving written notice of the revocation to the insurer and to the provider of the services. Requires that a written notice of revocation given to the insurer certifies that the covered person has given written notice of revocation to the provider of the services. Provides that the revocation of an election of direct payment is not effective until the insurer receives the notice. • Requires an insurer, who pays an insured after the insured has assigned payment, to also pay the provider of the services. • Prohibits policy provisions that require services be provided by a particular hospital or person, except as applicable to a group managed care plan or an HMO.
<p>Arkansas Arkansas Code §23-99-1201, et seq.</p>	<p>Insurers, health service corporations or HMO</p>	<p>All health care providers.</p>	<ul style="list-style-type: none"> • Permits an enrollee to assign to a healthcare provider the enrollee's right to receive reimbursement for any healthcare service rendered by a healthcare provider regardless of whether the healthcare provid-

Assignment of Benefits: Summary of State Requirements

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Effective 2019	Does not apply to supplemental, disability, and workers compensation health insurance policies.		<p>er is a participating provider or an out-of-network provider.</p> <ul style="list-style-type: none"> • Requires a health care provider in receipt of an assignment of benefits to provide notice of the assignment to the payor. • Requires a payor to promptly remit payment to a provider upon receipt of an assignment of benefits, and to provide written notice of that payment to the enrollee. • Prohibits waiver of these requirements via contract.
<p>California <i>Cal. Ins. Code §10126.6</i> Effective 1999</p>	Group or individual policies that provide hospital, medical, or surgical coverage and provide coverage for emergency health care services	Emergency medical transportation services	<ul style="list-style-type: none"> • Requires an insurer to provide coverage for emergency medical transportation services without regard to whether the emergency provider is contracted with the plan or whether there was prior authorization.
<p>California <i>Cal. Health and Safety Code §1371.4</i> Effective 2004 Amended 2008</p>	Health care service plans, or its contracting providers, that cover hospital, medical, or surgical expenses	Emergency services	<ul style="list-style-type: none"> • Requires plans or contracting medical providers to provide payment for emergency services. • Permits payment to be denied only if the plan reasonably determines that the emergency services were never performed.
<p>California <i>Cal. Ins. Code §10133</i> Effective 1951; Amended 1993</p>	Disability insurers.	Hospitalization or medical or surgical aid, physicians, surgeons, psychologists.	<ul style="list-style-type: none"> • Requires an insurer, with the written consent of the insured, to pay group benefits to the person(s) rendering care or to the person that paid for the services in an amount not to exceed that provided by the insurer for the expenses incurred. • Prohibits an insurer from requiring services be provided by a particular hospital or person.

Assignment of Benefits: Summary of State Requirements

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<p>Colorado <i>Colo. Rev. Stat. §10-16-317.5</i></p> <p>Effective 1992</p>	<p>Individual and group nonprofit hospital, medical-surgical, and health service corporations</p>	<p>All licensed hospitals and health care providers</p>	<ul style="list-style-type: none"> • Permits a subscriber to assign benefits under a contract and prohibits affected entities from including provisions in the contract which prevent assignments to licensed hospitals or health care providers. • Requires a licensed hospital or other licensed health care provider that receives an assignment of benefits to bill the contract issuer and include a copy of the assignment, and mail a copy of the bill to the subscriber or certificate holder, stating on such copy that it is for informational purposes only and that the payer has been billed for covered benefits. • Permits affected entities to maintain different levels of benefits, depending on whether a provider has entered into a contract or not.
<p>Colorado <i>Colo. Rev. Stat. §10-16-106.7</i></p> <p>Effective 2005 Amended 2019</p>	<p>Any carrier that provides health coverage</p>	<p>Licensed hospitals, health care providers, occupational therapists, and massage therapists</p>	<ul style="list-style-type: none"> • Permits a covered person to assign benefits under a contract to licensed hospitals, health care providers, occupational therapists, and massage therapists. • Permits the covered person to revoke an assignment of benefits upon written notice to the carrier of the revocation. • Requires a licensed hospital or other licensed health care provider that receives an assignment of benefits to bill the contract issuer and include a copy of the assignment, and mail a copy of such bill to the subscriber or certificate holder, stating on such copy that it is for informational purposes only and that the payer has been billed for covered benefits. • Makes a carrier that fails to pay a provider directly and pays the insured, who in turn does not pay the provider, liable to the provider for payment.

Assignment of Benefits: Summary of State Requirements

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<p>Connecticut <i>Conn. Gen. Stat. §§38a-491b and 38a-517b</i> Effective 2000 Amended 2011</p>	<p>Individual and group insurers, health care center, hospital and medical service corporation, or other entity delivering health insurance policies offering or administering dental benefits</p>	<p>Dental or oral surgery</p>	<ul style="list-style-type: none"> • Requires affected entities to accept or make reimbursement for an assignment of benefits to a dentist or oral surgeon when: <ul style="list-style-type: none"> ➢ the dentist or oral surgeon charges the insured, subscriber, or enrollee no more for services than the dentist or surgeon charges uninsured patients for the same services; and ➢ The dentist or oral surgeon allows the insurer, health care center, corporation, or entity to review the records related to the insured, subscriber, or enrollee during regular business hours and with notice to provider prior to the review.
<p>Connecticut <i>Conn. Gen. Stat. §38a-472</i> Effective 1990 Amended 2017</p>	<p>Third party that provides payment for bills incurred by an insured for medical, surgical, or hospital care</p>	<p>Medical, surgical, or hospital care.</p>	<ul style="list-style-type: none"> • Requires a third party, when notified by registered or certified mail of an assignment of benefits, to provide payment directly to the doctor, hospital, or state agency providing care.
<p>Connecticut <i>Conn. Gen. Stat. §38a-488a & § 38a-514</i> Effective 2018</p>	<p>Individual and group insurers</p>	<p>Diagnosis of treatment of a substance use disorder.</p>	<ul style="list-style-type: none"> • Mandates that reimbursement for covered services rendered in this state by an out-of-network health care provider for the diagnosis or treatment of a substance use disorder be paid under the insured's individual health insurance policy directly to the provider if the provider is otherwise eligible for reimbursement for such services.
<p>Delaware <i>Del. Code Ann. tit. 18 §2720</i> Effective 1953 Amended 1968</p>	<p>Life and health insurance policies.</p>	<p>Not specified.</p>	<ul style="list-style-type: none"> • Permits, but does not require, a policy to include terms for assignment of benefits. If an assignment is executed by the insured, the insurer may treat the assignee as the owner of the policy until the insurer has received at its home office written notice of termination of the assignment.

Assignment of Benefits: Summary of State Requirements

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<p>Delaware <i>Del. Code Ann. Tit. 18 §3367 and §3571H</i></p> <p>Effective 2013</p>	<p>Insurers, health service corporations or HMO</p> <p>Does not apply to supplemental health insurance policies that do not provide expense or reimbursement coverage for emergency medical services, basic life supports or ambulance services.</p>	<p>Emergency medical service provider or volunteer fire company provider</p>	<ul style="list-style-type: none"> Requires covered emergency medical services or supplies to be paid directly to a volunteer fire company or certified emergency medical services provider agency, without regard to whether a contract exists between a volunteer fire company or certified emergency medical services provider agency and an insurer, health services corporation, or HMO, and otherwise without regard to whether the volunteer fire company or emergency services provider is part of any network maintained by the insurer, health service corporation, or HMO.
<p>Florida <i>Fla. St. §627.638</i></p> <p>Effective 2005 Amended 2009</p> <p><i>Fla. St. §627.662</i> Effective 2003 Amended 2016</p> <p><i>Informational bulletin 83-242</i></p>	<p>Health insurers; group, blanket, and franchise health insurers, dental providers, hospitals, physicians, dental providers, and pharmacists.</p>	<p>Medical and hospital services. Dental and medical procedures.</p>	<ul style="list-style-type: none"> Permits an insurer to provide payment of benefits directly to the hospital, licensed ambulance provider, physician, dentist or person rendering services covered by the policy. Requires all claim forms to provide an option for payments directly to the provider. Limits the payment to the provider from the insurer to no more than the amount that the insurer would otherwise have paid.
<p>Georgia <i>GA. Code Ann. §33-24-54</i></p> <p>Effective 1992</p>	<p>Accident and sickness policies, subscriber contracts.. Does not apply to credit insurance, disability income insur-</p>	<p>Licensed health care providers</p>	<ul style="list-style-type: none"> Requires the direct payment of benefits for health care services that are payable under a contract to a participating or preferred provider to any similarly licensed nonparticipating or non-preferred provider who has rendered such services, has a written assignment of benefits, and has provided written notice of such assignment.

Assignment of Benefits: Summary of State Requirements

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Amended 2006	ance, or limited accident and sickness policies such as hospital indemnity policies, specified disease policies, limited accident policies, or similar limited policies. Does not apply to health benefit plans governed by ERISA ²		<ul style="list-style-type: none"> Permits the payment of different levels of benefits, and having differences in co-payment percentages applicable to benefit levels, for services provided by participating or preferred providers and non-participating or non-preferred providers.
Idaho <i>Idaho Code §41-3417</i> Effective 1992	Hospital and professional service corporations	Dental care benefits	<ul style="list-style-type: none"> Allows subscribers to direct the payment of dental care benefits to which the subscriber is entitled, pursuant to the contract, be made in the name of the nonparticipating licensee providing covered dental care services which are authorized by the subscriber's contract. Permits contracts to provide lesser benefits for services rendered by nonparticipating licensees and/or nonparticipating hospitals than those provided by participating licensees and/or participating hospitals.
Illinois <i>215 Ill. Comp. Stat. 5/370a</i> Effective 1999 Amended 2000	Accident and health insurers, health maintenance organizations, managed care plans, health care plans, preferred provider organizations, or third-party administrators	Health care professionals or facilities.	<ul style="list-style-type: none"> Requires affected entities to honor an assignment by an enrollee or insured to a health care professional or facility and to make direct payment of the claim including any interest due for failure to pay a claim within 30 days of receipt of claim.

² The district court in [Griffin v. Verizon, 2015 WL 9920819, July 29, 2015](#), held that ERISA preempted this statute. Thus, the provision requiring recognition of assignments of benefits in insurance contracts does not apply to health benefit plans governed by ERISA.

Assignment of Benefits: Summary of State Requirements

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<p>Kentucky <i>Ky. Rev. Stat. Ann. §304.14-250(4)</i> Effective 1970</p>	Group insurance and annuity policies.	Not specified.	<ul style="list-style-type: none"> Permits an insured, unless expressly prohibited under the terms of the contract, to assign to another person his/her rights and benefits under the contract. Permits an insurer to treat an assignee as the owner of such rights and benefits in accordance with the terms of the assignment.
<p>Louisiana <i>LSA-R.S. 40:2010³</i> Effective: 1987</p>	Insurance companies, employee benefit trusts, self-insurance plans, or other entities obligated to reimburse or pay charges	Licensed hospitals	<ul style="list-style-type: none"> Requires affected entities to pay licensed hospitals when the itemized statement submitted to such entity clearly indicates that an individual insured's rights to those benefits have been assigned to the hospital. Provides that payment to the insured neither releases an affected entity from liability to the hospital to which the benefits have been assigned, nor provides a defense to any action by the hospital against that entity to collect the assigned benefits.
<p>Maine <i>Me. Rev. Stat. Ann. Tit. 24-A, §§ 2827-A, 2755, 4207-A, and Tit. 24 §2332-H</i> Effective 1999</p>	Individual, group and blanket policies, non-profit hospitals and medical service organizations providing medical and dental care on expense-incurred basis and HMOs	Medical and dental care services	<ul style="list-style-type: none"> Requires all policies and certificates providing benefits for medical or dental care on an expense-incurred basis or point of service contracts to contain a provision permitting the insured to assign benefits for such care to the provider. Provides that an assignment of benefits does not affect or limit the payment of benefits otherwise payable under the contract.

³ A federal trial court held in [Louisiana Health Service & Indem. Co. v. Rapides Healthcare System, M.D.La.2002, 213 F.Supp.2d 650](#), that ERISA did not preempt the Louisiana statute requiring insurers to honor all patients' assignments of benefits, even if benefits were assigned to a health care provider that did not have a contract with the insurer providing for direct payment.

Assignment of Benefits: Summary of State Requirements

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<p>Maryland <i>MD Code, Insurance,</i> § 15-138 Effective 2012 Amended 2015</p>	<p>Individual or group health care policies, except those issued by an HMO.</p>	<p>Ambulance service providers</p>	<ul style="list-style-type: none"> • Requires direct reimbursement of an ambulance service provider that obtains an assignment of benefits from an insured, subscriber or enrollee for covered services provided. • Prohibits an ambulance service provider from balance billing a covered individual, but allows an ambulance service provider to collect or attempt to collect any copayment, deductible, or coinsurance amount owned by the insured, subscriber, or enrollee for covered services rendered.
<p>Maryland <i>MD Code, Insurance,</i> § 14-205.3 Effective 2011</p>	<p>An insurer acting as a preferred provider organization</p>	<p>Health services</p>	<ul style="list-style-type: none"> • An insurer may not: <ol style="list-style-type: none"> (1) prohibit the assignment of benefits to a provider who is a physician by an insured; or (2) refuse to directly reimburse a non-preferred provider who is a physician under an assignment of benefits. • If an insured has not provided an assignment of benefits, the insurer shall include the following information with the payment to the insured for health care services rendered by the non-preferred provider who is a physician: <ol style="list-style-type: none"> (1) the specific claim covered by the payment; (2) the amount paid for the claim; (3) the amount that is the insured's responsibility; and (4) a statement instructing the insured to use the payment to pay the non-preferred provider in the event the insured has not paid the non-preferred provider in full for the health care services rendered by the non-preferred provider. • If a physician who is a non-preferred provider seeks an assignment of benefits from an insured, the physician shall provide the following information to the insured, prior to performing a health care service: <ol style="list-style-type: none"> (1) a statement informing the insured that the physician is a non-preferred provider; (2) a statement informing the insured that the physician may charge the insured for non-covered services;

Assignment of Benefits: Summary of State Requirements

State/ Citation	Applicability	Services and/or Providers Covered	Key Provisions
			<p>(3) a statement informing the insured that the physician may charge the insured the balance bill for covered services;</p> <p>(4) an estimate of the cost of services that the physician will provide to the insured;</p> <p>(5) any terms of payment that may apply; and</p> <p>(6) whether interest will apply and, if so, the amount of interest charged by the physician.</p> <ul style="list-style-type: none"> An insurer may refuse to directly reimburse a non-preferred provider under an assignment of benefits if: <ol style="list-style-type: none"> (1) the insurer receives notice of the assignment of benefits after the time the insurer has paid the benefits to the insured; (2) the insurer, due to an inadvertent administrative error, has previously paid the insured; (3) the insured withdraws the assignment of benefits before the insurer has paid the benefits to the non-preferred provider; or (4) the insured paid the non-preferred provider the full amount due at the time of service.
<p>Massachusetts <i>M.G.L.A. 176I § 3</i> Effective 1988 Amended 2000</p>	<p>Health benefit plans</p>	<p>Emergency care services</p>	<ul style="list-style-type: none"> Requires payment for emergency care for covered individuals who cannot reasonably reach a preferred provider, payment for care related to the emergency to be made at the same level and in the same manner as if the covered person had been treated by a preferred provider.
<p>Mississippi <i>Miss. Code Ann. §41-9-51</i> Effective 2008 Amended 2011</p>	<p>Health care insurers.</p>	<p>Trauma care team and trauma care services.</p>	<ul style="list-style-type: none"> Requires an insurer to reimburse a hospital, if assigned by the patient, the cost of activating a trauma care team in response to a request regardless of whether services were actually rendered to the patient, and those trauma care services shall be deemed as a matter of law to have been medical services provided to the patient.
<p>Mississippi</p>	<p>Commercial insurers</p>	<p>Health care services</p>	<ul style="list-style-type: none"> Prohibits the restriction of an insured's ability to assign the in-

Assignment of Benefits: Summary of State Requirements

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<p><i>Miss. Code Ann. §83-9-3</i></p> <p>Effective 2013 Amended 2016</p>	<p>providing individual or group policies covering health and accident insurance.</p>		<p>insured's benefits under the policy to a licensed health care provider that provides health care services to the insured.</p> <ul style="list-style-type: none"> Commercial insurers doing business in this state shall honor an assignment for a period of one (1) year starting from the initial date of an assignment. If the insured provides the insurer with written direction that all or a portion of any indemnities or benefits provided by the policy be paid to a licensed health care provider rendering hospital, nursing, medical or surgical services, then the insurer shall pay directly the licensed health care provider rendering such services. That payment shall be considered payment in full to the provider, who may not bill or collect from the insured any amount above that payment, other than the deductible, coinsurance, copayment or other charges for equipment or services requested by the insured that are non-covered benefits.
<p>Missouri</p> <p><i>Mo St 376.427</i></p> <p>Effective 1990 Amended 2018</p>	<p>Insurers, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.</p>	<p>Health care services including medical, surgical, dental, podiatric, pharmaceutical, chiropractic, licensed ambulance service, and optometric services</p>	<ul style="list-style-type: none"> Requires Insurers, upon receipt of an assignment of benefits made by the insured to a provider, to issue payment for a claim in the name of the provider. Requires all claims to be paid within 30 days of the receipt by the insurer of all documents reasonably needed to determine the claim.
<p>Missouri</p>	<p>Health service corpora-</p>	<p>Pharmacy goods and ser-</p>	<ul style="list-style-type: none"> Permits assignments of pharmacy benefits to pharmacists.

Assignment of Benefits: Summary of State Requirements

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<p><i>Mo. St. §354.090</i> Effective 1983</p>	<p>tions</p>	<p>vices</p>	<ul style="list-style-type: none"> Requires health service corporations to pay the pharmacist any payment due the insured under the terms of the policy or contract.
<p>Missouri <i>Mo. St. §354.535</i> Effective 2006</p>	<p>HMOs</p>	<p>Pharmacy goods and services</p>	<ul style="list-style-type: none"> Permits assignment of benefits to any pharmacy in an emergency when all the pharmacies contracted with the HMO are closed. Requires HMOs to apply the same co-insurance, co-payments, and deductibles for all networked pharmacists for the same medication. Waives this provision in the case of comparing generic and brand name drugs.
<p>Missouri <i>Mo. St. §376.778</i> Effective 1983</p>	<p>Individual accident and sickness</p>	<p>Public hospitals or clinics</p>	<ul style="list-style-type: none"> Requires a contract provision whereby the benefits payable to an insured must be paid, with or without an assignment from the insured, to public hospitals or clinics for services and supplies provided to the insured if a proper claim is submitted by the public hospital or clinic. Makes an exception to the requirement if benefits have been paid to the insured prior to receipt of a claim submitted by the public hospital or clinic. Provides that payment to the public hospital or clinic of benefits discharges affected entities from all liability to the insured to the extent of the benefits so paid. States that the provisions do not require payment of benefits for the same services or supplies to both the insured and the public hospital or clinic.

Assignment of Benefits: Summary of State Requirements

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<p>Missouri <i>Mo. St. §190.205</i></p> <p>Effective 1998</p>	Health carriers and managed care plans	Ambulance services or emergency medical response agencies	<ul style="list-style-type: none"> Requires affected entities to pay benefits directly to ambulance services or emergency medical response agencies.
<p>Nevada <i>Nev. Rev. Stat. 689A.135 and 689B.040</i></p> <p>Effective 1983</p>	Health insurers	Hospital, nursing, medical, surgical, home health, and supportive services	<ul style="list-style-type: none"> Allows assignment of benefits to providers providing services covered by the policy. Requires affected entities to pay all or the part of the benefits assigned by the insured. Provides that a payment made pursuant to this subsection discharges the insurer's obligation to pay those benefits, however, requires that if the insured makes an assignment, but the insurer, after receiving a copy of the assignment, pays the benefits to the insured, the insurer must also pay those benefits to the provider who received the assignment as soon as the insurer receives notice of the incorrect payment.
<p>Nevada <i>Nev. Rev. Stat. 689B.047</i></p> <p>Effective 1989</p>	Health insurers providing group health insurance policies	Medical transportation services	<ul style="list-style-type: none"> Requires group policies that provide coverage for medical transportation to contain a provision for the direct payment of a provider for services if covered and if the provider does not receive reimbursement from another source.
<p>Nevada <i>Nev. Rev. Stat. 449.2475</i></p> <p>Effective 2007</p>	Health insurers not licensed in the state of Nevada	Services provided by a hospital or other healthcare provider that an insurer is obligated to cover	<ul style="list-style-type: none"> Prohibits an insurer that is not licensed in the state of Nevada from directly paying the benefits to a person when the insurer has notice that the person has assigned rights to the benefit to the hospital or provider of the services.

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			<ul style="list-style-type: none"> • It does not provide grounds for civil or criminal liability.
<p>New Hampshire <i>N.H. Rev. Stat. § 420-B:8-n</i> Effective 2002</p>	<p>Point-of-Service (POS) plans issued by HMOs</p>	<p>Medical or dental care</p>	<ul style="list-style-type: none"> • Requires all POS contracts to contain a provision permitting an enrollee to assign benefits for medical or dental care on an expense-incurred basis to the provider of care.
<p>New Jersey <i>N.J. Stat. Ann. §17B:30-59</i> Effective 2008</p>	<p>Insurers, health service corporations, hospital service corporations, medical service corporations, and HMOs</p>	<p>Ambulance services</p>	<ul style="list-style-type: none"> • Permits an insured, through the assignment of benefits, to provide reimbursement for ambulance services regardless of if the provider of the emergency services is contracted with the carrier. • Requires the payer to remit payment within a given timeframe. • Considers a claim unpaid if the payer sends payment to the insured rather than the provider. • Subjects overdue payments to accruing interest.
<p>New Jersey <i>N.J. Stat. Ann. §17B:24-4</i> Effective 1972</p>	<p>Insurers</p>	<p>Any benefits as outlined in the policy contract</p>	<ul style="list-style-type: none"> • Permits an insured to assign or not assign benefits as provided by the terms of the policy. • Permits the insurer to deal with the assignee as the owner of the policy.
<p>New Jersey <i>N.J. Stat. Ann. §17:48C-8.3; §17:48D-9.6; §17:48E-10.2</i></p>	<p>Dental service corporations, dental plan organization, and health service corporations</p>	<p>Dental services</p>	<ul style="list-style-type: none"> • A covered person may enter into an agreement with an out-of-network dentist to sign over the dental benefit payment received from the dental service corporation to the dentist. The agreement shall: (1) be in writing; (2) be signed by the person who is entitled to receive the dental benefit payment from the dental service corporation; (3) be retained by the dentist for at least six years

Assignment of Benefits: Summary of State Requirements

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Effective 2013			<p>following the date of the most recent payment from the covered person; and (4) give the covered person at least 10 business days within which to sign over the dental benefit to the dentist.</p> <ul style="list-style-type: none"> • A covered person who agrees to sign over a dental benefit payment in accordance with this section shall comply with the terms of the agreement; except that, if the covered person owes the out-of-network dentist less than the amount of the dental benefit payment, the covered person shall pay the dentist the balance owed to the dentist. • A covered person who fails to sign over the dental benefit payment shall be liable to the out-of-network dentist for payment of attorney fees and costs reasonably incurred by the dentist in enforcing the agreement established pursuant to those subsections. • With respect to a dental service corporation that makes a dental benefit payment to a covered person for services rendered by an out-of-network dentist, if the covered person assigns, through an assignment of benefits, his right to receive reimbursement to an out-of-network dentist, the dental service corporation shall issue the payment for the reimbursement directly to the dentist in the form of a check payable to the dentist, or in the alternative, to the dentist and the covered person as joint payees, with a signature line for each of the payees. Any payment made only to the covered person rather than the dentist while such an assignment of benefits is in effect shall be considered unpaid, and unless issued to the dentist within the time frames shall be considered overdue and subject to interest charges as provided in that section.
<p>North Carolina <i>N.C. Gen. Stat. §58-3-225</i></p>	<p>Insurers; hospital, medical and dental service corporations; health maintenance organiza-</p>	<p>Licensed health care providers.</p>	<ul style="list-style-type: none"> • Defines a “claimant” as a health care provider or facility that is responsible or permitted under contract with the insurer or by valid assignment of benefits for directly making the claim with an insurer.

Assignment of Benefits: Summary of State Requirements

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Effective 2000; Last amended 2009	tions; and multiple employer welfare groups that write health benefit plans.		<ul style="list-style-type: none"> Requires an insurer to remit payment, provide notice of denial, or provide notice of an incomplete claim filing to a claimant within 30 days of receiving a claim. Subjects an insurer to an 18% interest rate for the unpaid claim.
Ohio <i>Ohio Rev. Code Ann. §3901.386</i> Effective 2001	Third-party payers	Hospital-based emergency service	<ul style="list-style-type: none"> Requires a third-party payor to accept and honor a completed and validly executed assignment of benefits if the third-party payer and the hospital have not entered into a contract regarding the provision and reimbursement of covered services and the third-party payer has not notified the hospital of its assignment restrictions. Prohibits third-party payers from refusing to accept and honor a validly executed assignment of benefits with a hospital for medically necessary hospital services provided on an emergency basis.
Pennsylvania⁴ <i>40 Pa.C.S.A. § 6326(5)</i> Effective 1972	Professional health services plan corporations.	Not specified.	<ul style="list-style-type: none"> Permits an insurance policy to include in a contract an agreement that benefits cannot be assigned.
Rhode Island <i>R.I. Gen. Laws §§ 27-18-63, 27-19-54, 27-20.1-18, 27-41-66, and 27-20-49</i>	Accident and sickness policies for group or individual, nonprofit service corporations, HMOs, and nonprofit medical service corpo-	Dental services	<ul style="list-style-type: none"> Requires affected entities to allow any person insured by such entity to direct, in writing, that benefits from a health benefit plan, policy or contract, be paid directly to a dental care provider who has not contracted with the entity to provide dental services to persons covered by the entity but otherwise meets the credentialing criteria of the entity and has not previously been terminated by such entity

⁴ [Kassab v. Medical Service Association of Pennsylvania, 39 Pa. D. & C.2d 723, 1966](#), stated that a non-participating provider that performed medical services for certain Blue Shield subscribers could not have benefits assigned to him, even though he was a former participant in the Blue Shield Plan and the subscribers to whom he provided services requested payment be assigned to him, because the assignments were specifically prohibited under the Blue Shield subscription agreement.

Assignment of Benefits: Summary of State Requirements

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Effective 2004	<p>rations.</p> <p>Does not apply to: hospital confinement indemnity; disability income; accident only; long-term care; Medicare supplement; limited benefit health; specified disease indemnity; sickness or bodily injury or death by accident or both; and other limited benefit policies.</p>		<p>as a participating provider.</p> <ul style="list-style-type: none"> • Requires, if written direction to pay is executed and written notice of the direction to pay is provided to such entity, the insuring entity to pay the benefits directly to the dental care provider. • Prohibits any efforts to modify the amount of benefits paid directly to the dental care provider under this section that includes a reduction in benefits paid of more than 5% less than the benefits paid to participating dentists. • Gives the affected entity paying the dentist, pursuant to a direction to pay duly executed by the subscriber, the right to review the records of the dentist that relate exclusively to that particular subscriber/patient to determine that the service in question was rendered.
<p>South Dakota <i>S.D. Codified Laws §58-17-61</i> Effective 1989</p>	<p>Health insurance companies, HMOs, PPOs, IPAs, or nonprofit hospital service corporation</p>	<p>Licensed hospitals</p>	<ul style="list-style-type: none"> • Permits enrollees to assign in writing benefits to a licensed hospital. • Requires the affected entity to pay the benefits directly to the hospital if the assignment is executed and written notice is given.
<p>South Dakota <i>S.D. Codified Laws § 58-17-163 and § 58-17-164</i> Effective 2017</p>	<p>Dental Care Insurers</p>	<p>Dental care services</p>	<ul style="list-style-type: none"> • Permits enrollees to assign in writing benefits to a dentist or dental corporation for dental care services. This assignment can be revoked by the enrollee without consent of the dentist or dental corporation by way of a written revocation. • Requires insures to make payments directly to the dentist or dental corporation providing the dental care services. • Provides that a person may revoke an assignment in writing with or without the consent of the dentist or dental corporation. The revoca-

Assignment of Benefits: Summary of State Requirements

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			<p>tion is effective when both the insurer and the dentist or dental corporation have received a copy of the revocation notice. The revocation is only effective for any charges incurred after both parties have received the revocation notice.</p>
<p>Tennessee⁵ <i>Tenn. Code Ann. §56-7-120</i></p> <p>Effective 1997 Amended 2019</p>	<p>Insurers</p>	<p>Medicine, osteopathy, dentistry, chiropractic, podiatry or optometry, pharmacy, hospital, home health, infusion therapy, or DME</p>	<ul style="list-style-type: none"> • Permits the insured or other persons entitled to benefits under a policy to assign those benefits to the health care provider of those services. • Requires notice of such assignment, unless otherwise provided by contract, to be in writing to the insurer for the assignment to be effective. • An insured's assignment of benefits, may be disregarded by an insurer if: <ul style="list-style-type: none"> ▪ The assignment of benefits is to a non-participating facility-based physician; and ▪ All of the following conditions are not satisfied: <ol style="list-style-type: none"> (i) <ol style="list-style-type: none"> (a) The healthcare facility provides written notice to the insured that informs the insured that: <ol style="list-style-type: none"> (1) The non-participating facility-based physician may not have a current contract provider agreement with the insured's insurer; and (2) The insured may receive a bill for medical services from the non-participating facility-based physician for the amount unpaid by the insured's insurer; (b) The notice required shall be provided to the insured, or the insured's personal representative, prior to when the insured first receives services from the nonparticipating facility-based physician. In circumstances where the insured is receiving medical services through a hos-

⁵ In [Dialysis Newco, Inc. v. Community Health Systems Group Health Plan](#), 2019, the Fifth Circuit held that ERISA preempted the application of this statute's anti-assignment prohibition to benefit plans subject to ERISA.

Assignment of Benefits: Summary of State Requirements

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			<p>pital emergency department or is incapacitated or unconscious at the time of receiving such services, the notice will not be required. The failure of the healthcare facility to provide the notice required shall not give rise to any right of indemnification or private cause of action against the healthcare facility by any non-participating facility-based physician for an insurer's disregard of an insured's assignment of benefits unless the healthcare facility's failure to provide such notice is due to willful or wanton misconduct of an agent of the healthcare facility; and</p> <p>(ii) The non-participating facility-based physician provides the insured a billing statement that:</p> <ul style="list-style-type: none"> (a) Contains an itemized listing of the services and supplies provided along with the dates when the services and supplies were provided; (b) Contains a conspicuous, plain language explanation that: <ul style="list-style-type: none"> (1) The non-participating facility based physician does not have a current contract provider agreement with the insured's insurer; and (2) The insurer has paid a rate, as determined by the insurer, that is below the non-participating facility-based physician's billed amount; (c) Contains a telephone number to call to discuss the billing statement, provide an explanation of any acronyms, abbreviations, and numbers used on the statement, or discuss any payment issues; (d) Contains a statement that the insured may call to discuss alternative payment arrangements; and (e) For billing statements that total an amount greater than \$200, over any applicable copayments, coinsurance or deductibles, states, in plain language, that if the insured finalizes a payment plan agreement within 45

Assignment of Benefits: Summary of State Requirements

State/ Citation	Applicability	Services and/or Providers Covered	Key Provisions
			<p>days of receiving the first billing statement and substantially complies with the agreement, the non-participating facility-based physician shall not furnish adverse information to a consumer reporting agency regarding an amount owed by the insured.</p>
<p>Tennessee <i>Tenn. Code. Ann. §68-11-219</i></p> <p>Effective 2000</p>	<p>Insurers offering health, accident and sickness insurance policies</p>	<p>Physician, dentist, hospital, nursing home, home for the aged, residential HIV supportive living facility, assisted-care living facility, alcohol and drug prevention and/or treatment facility, birthing center, prescribed child care center, ambulatory surgical treatment center, community mental health center, home care organization, or other such health care agency</p>	<ul style="list-style-type: none"> • Requires insurers, upon assignment, to pay a covered provider the benefits due under a policy within 30 days from the time the insurance company has received a final billing statement for the health care services from the covered provider.
<p>Texas <i>TX Ins. § 1204.053 and 1204.054</i></p> <p>Effective 1991 Amended 2005</p>	<p>Health insurers</p>	<p>Physician or other health care provider services</p>	<ul style="list-style-type: none"> • Prohibits insurers from restricting a written assignment of benefits by insured to a physician or other health care provider who provides health care services to the person. • Permits verification through the insurer's normal process for the health care services the physician or other health care provider provides to the covered person. • Requires an insurer to pay benefits directly to a physician or other health care provider, and relieves the insurer of the obligation to pay those benefits to the covered person if: <ul style="list-style-type: none"> ➤ the covered person makes a written assignment of those bene-

Assignment of Benefits: Summary of State Requirements

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			<ul style="list-style-type: none"> fits; and ➤ the assignment is obtained by or delivered to the insurer with the claim for benefits.
<p>Virginia VA. Code Ann. §38.2-4215 Effective 1986</p>	<p>Non-stock corporations with subscription contracts must pay assignments where charges are less than 80% covered charges.</p>	<p>Hospitals and health care providers</p>	<ul style="list-style-type: none"> • Prohibits affected entities from denying subscribers the right to assign benefits, unless the benefit is 80% of covered charges or greater.
<p>Virginia VA. Code Ann. §38.2-3407.13 Effective 1999</p>	<p>Individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, corporations providing individual or group accident and sickness subscription contracts, and dental service plans</p>	<p>Dentists and oral surgeons</p>	<ul style="list-style-type: none"> • Prohibits affected entities from refusing to accept or make reimbursement pursuant to an assignment of benefits made to a dentist or oral surgeon by an insured, subscriber, or plan enrollee. • Provides that an assignment of benefits is not effective until the insured, subscriber, or enrollee notifies the insurer, corporation or plan in writing of the assignment.
<p>Virginia VA. Code Ann. §38.2-3407.9 Effective 2000 Amended 2015</p>	<p>Insurers offering accident and sickness policies providing ambulatory services</p>	<p>Ambulance services</p>	<ul style="list-style-type: none"> • Requires direct payment under assignments to any person providing services provided by an emergency services vehicle if the accident and sickness insurance policy provides coverage for ambulance services.

Assignment of Benefits: Summary of State Requirements

State/ Citation	Applicability	Services and/or Providers Covered	Key Provisions
<p>Virginia <i>VA. Code Ann. §38.2-3407.13:2</i> Effective 2006</p>	<p>Insurers, health services plan and HMOs</p>	<p>Health services from physicians and osteopaths</p>	<ul style="list-style-type: none"> • Requires affected entities that follow a policy of sending payment to the insured for a claim for services received from a nonparticipating physician or osteopath, to: <ul style="list-style-type: none"> ➤ include language in the certificate or evidence of coverage of the insured that notifies the insured of the responsibility to apply the plan payment to the claim from such nonparticipating provider; ➤ include the above language with any such payment sent to the insured; and ➤ include the name and any last known address of the nonparticipating provider on the explanation of benefits statement.
<p>Wyoming <i>Wyo. Stat. Ann. §25-11-106</i> Effective 1991 Amended 1993</p>	<p>Insurers</p>	<p>Services and care in state institutions</p>	<ul style="list-style-type: none"> • Requires the Department of Health to obtain an assignment of benefits from any resident under its care and supervision in a state institution who has insurance that may cover services provided.
<p>Wyoming <i>Wyo. Stat. Ann. §26-15-136</i> Effective 1993</p>	<p>Third-party agencies and insurers administering medical assistance contracts</p>	<p>Medical, surgical, and hospital care including physician services, nursing services, and pharmaceutical services</p>	<ul style="list-style-type: none"> • Requires affected entities that provide payment to, or on behalf of, an applicant or recipient of medical assistance to provide payment as assigned by the enrollee directly to the provider.