Assignment of Benefits and Direct Payment Form

Please complete all sections below to authorize direct payment of medical benefits to the provider.

1. Patient Information

Patient Full Name:

Date of Birth (MM/DD/YYYY):

Phone Number:

Street Address:

City, State, Zip Code:

2. Insurance Information

Insurance Company Name:

Policy / ID Number:

Group Number:

Insured / Policy Holder Name (if different from patient):

3. Assignment of Benefits & Authorization

I hereby instruct and direct my insurance company to pay by check or electronic transfer directly to the medical provider/facility providing services. This payment represents the medical benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

I agree to be financially responsible for any charges not covered by this assignment or my insurance company.

4. Authorization Signature

Printed Name of Patient or Authorized Representative:

Relationship to Patient (if signed by Representative):

Date (MM/DD/YYYY):

Handwritten Signature (Sign here after printing):