Assignment of Benefits (AOB) Form

Patient Information:

Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Insurance ID: _____

Provider Information:

Provider Name: _____

Provider Address: _____

Phone: _____ NPI #: _____

Insurance Company: _____

Statement of Authorization:

I hereby authorize direct payment of medical benefits to the provider named above for any services rendered. I understand that I am financially responsible for any charges not covered by my insurance plan.

I also authorize the release of any medical or other information necessary to process this claim. This authorization shall remain valid until revoked by me in writing.

Signature of Patient/Guardian: _____ Date: _____

Witness: _____ Date: _____