



Assignment of Benefits

Patient Name: _____

MEDICARE AND COMMERCIAL INSURANCE CARRIERS

I request that all payment of all authorized Medicare and/or insurance benefit payments be made on my behalf directly to Premier Medical Group, P.C. for services furnished to me. I authorize Premier Medical Group, P.C. to release information about my office visits to Medicare and/or my insurance carrier and it's agents. This information will be provided as necessary, in order for Premier Medical Group, P.C. to obtain payments from Medicare and/or my insurance carrier for medical treatment provided.

This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original document.

Patient Signature: _____ Date of Birth: _____

Today's Date: _____

ACCIDENT/LIABILITY INSURANCE

I authorize Premier Medical Group, P.C. to release any medical information or information pertinent to my medical benefits, including major medical benefits to which I am entitled, if required to process my insurance claims. I hereby authorize Premier Medical Group, P.C. to file claims on my behalf to my Worker's Compensation, No-Fault or Medi-Pay insurance carrier, and assign all applicable insurance payments to be made directly to Premier Medical Group, P.C.

If, for any reason my insurance carrier rejects a claim, or refuses payments, I agree to be responsible for the fees incurred. I therefore agree to pay Premier Medical Group, P.C. their usual & customary fees for services rendered.

This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original document.

Patient Signature: _____ Date of Birth: _____

Today's Date: _____