Assignment of Benefits Form

Practice Name Advanced Neurosurgery Associates

Address 201 Route 17 North, Suite 501

City, State, Zip Rutherford, NJ 07070

Phone 201-457-0044

Date _____

Patient: _____

Employer: _____

Claim Group: _____

SS# / ID#: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:

Advanced Neurosurgery Associates 201 Route 17 North Suite 501 Rutherford, NJ 07070

or

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

_____

for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. If payment is mailed directly to me I will bring in the check and explanation of benefits within 1 week of receipt.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner or my health care provider for any reason on my behalf.

Dated at _____ this _____ day of _____, 20

_____
Signature of Policyholder

_____Signature of Claimant, if other that Policyholder.