



HEALTH INSURANCE

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

RE:

Patient: _____
 Employer: _____
 Claim/Group Number (if Medicare NONE): _____
 SS#/ID# _____

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

**Spring Grove Physical Medicine & Rehabilitation,
 2100 Route 12, Suite 100, Spring Grove, IL 60081**

OR

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

c/o

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered THIS 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.

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.

Dated at
 Spring Grove Physical Medicine & Rehabilitation.

 Policyholder Signature

 Witness

 Claimant Signature

 Date