HEALTH CHOICE CLINIC

Assignment of Insurance Benefit/Eligibility		
Primary Insurance Plan		
Insurance Plane	Group #	Policy #
Insurance Company Address	Phone #	
Subscriber Name	Relationship to Patient	
Subscriber Certificate/Social Security #	Subscriber Date of Birth	
Subscriber Employer	Employer Phone #	
Employer Address		
For Medicare Patients Only		
Health Insurance Claim #	Part A Effective Date	Part B Effective Date
Other Health Insurance For Patient		
Patient Name	Date of Birth	
Insurance Plan	Group #	Policy #
Insurance Company Address	Phone #	
Subscriber Name	Relationship to Patient	
Subscriber Social Security #	Subscriber Date of Birth	
Subscriber Employer	Employer Phone #	
Employer Address:		

_____ I hereby authorize and request that payment of authorized Medicare/other insurance company benefits be made on my behalf, be paid directly to Health Choice Clinic for any medical services rendered to me or a member of my family. I authorize any holder of medical or other

HEALTH CHOICE CLINIC

information about me to release to the Social Security Administration, Health Care Financing Administration, its agents or carriers, or the insurance company any information needed for this or a related Medicare/other insurance claim to determine these benefits or the benefits payable for related services. I understand that it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment.

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Name of Patient/Responsible Party Relationship