Print

Clear Form

HEALTH INSURANCE ASSIGNMENT OF BENEFITS AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with the insurance company information provided to Heroes Healthcare Primary Care. I authorize Heroes Healthcare Primary Care to release any medical information about me or my dependent that is/was a patient of Heroes Healthcare Primary Care to the insurance company identified below and its agents for the purpose of determining benefits or payment of benefits for today's office visit. I also request that payment of benefits be made on my behalf directly to Heroes Healthcare Primary Care from my health insurance carrier identified below.

I further understand that I am financially responsible for all services provided by Heroes Healthcare Primary Care that are not covered by my insurance carrier.

Insurance Carrier: _____

Policy Number: _____

Group Number: _____

Effective Date of Coverage: _____

Primary Member Name: _____

Primary Member Date of Birth: _____

_____ _____

Signature of Patient/Guardian **Date**