MedFlorida
Medical Centers

MOTOR VEHICLE AGENCY INITIAL INFORMATION

Claim: _____

MVA Insurance Company: _____

Policy Number: _____

Address: _____

City, State and Zip: _____

Phone: _____

Adjuster's Name: _____

Patient's Name: _____

Date of Accident: _____

MedFlorida
Medical Centers

ASSIGNMENT OF BENEFITS

Patient Name:_____

Insurer:_____

Claim # _____ Date of Accident: _____

I, the undersigned patient, by my signature below, for good and valuable consideration, including credit extended to me, hereby IRREVOCABLY ASSIGN, transfer and convey to: _____ (hereinafter _____and/or assignee), all of my rights, title and interest in any medical benefit(s) payer available to me to pay for medical expenses I incur in my treatment with _____. This Assignment of Benefits (AOB) shall include any personal injury protection (P.I.P.) coverage related to my current situation, as well as any other automobile liability, medical payment insurance, or other health insurance benefit or indemnification and/or agreement otherwise payable to me.

The payment to the above insured's name or any insurance covering any injuries I sustained on the above date of accident shall be directly sent to assignee or their named representative.

I further authorize _____ to negotiate or demand payment, collect, bring suit and settle any claim against any insurance carrier or other third-party payer with regard to these services. This AOB includes authority to request and receive from my insurer or any other party payer, any and all documentation and record(s) that I could obtain regarding the above noted accident claim, including without limitation any party's Medical Examination reports, any other records or review and reports on such records, and any information regarding to the P.I.P payment sheet(s) (full disclosure update) or payment log(s), without regard to whether such documentation has already been provided to me.

I hereby instruct said insurer that in the event the subject medical benefits are disputed or unpaid for any reason, including but not limited to any issue regarding medically reasonable treatment or medically necessary treatment, that the amount of benefits claimed by _____ are set aside and not disbursed for any reason, including my direction to set aside funds for any other claims, such as lost wages, until the assignee's dispute is resolved. As part of this AOB, I further instruct the insurance carrier to notify _____ immediately of any dispute as to payment so that they may exercise their legal rights. I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a statement containing any false, incomplete, or misleading information is guilty of a felony third degree.

I have read this information herein and which is true to the best of my knowledge and belief. This is a direct and irrevocable assignment of my rights and benefits under my policy of insurance which shall become effective upon acceptance of _____ and by my signature below.

_____ _____ _____

Patient name printed Patient Signature Date

I hereby accept assignment: _____ _____

Date

_____ D/B/A _____