NeuroScience Associates

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Patient Name:___________________________

Assignment of Insurance Benefits

I authorize payment of medical benefits and or government benefits to the party who accepts assignment. I authorize payment of medical benefits to the undersigned physician or supplier for services preformed.

Signature:________________________________Date:__________________

Medicare Patients only

Medigap Authorization

Medicare #:____________________________

I request that payment that payment of authorized Medigap benefits be a made either to me or on my behalf to ________________________________for an services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to my designated insurer any information needed to determine these benefits or the benefits payable for related services.

Signature of Beneficiary__________________________ Date:____________