Assignment of My Benefits

Benefit Info

What is your deductible amount? $_____ and Coinsurance %_____ (for service you are seeking)

If you don't know this information, cal the "800" number on your insurance card. The front desk person may be able assist you.

If you have a coinsurance or unmet deductible give your credit card info here. Nothing will be changed unless a balance due.
Credit Card Type: _____ Exp. Date_____ Card # _____

I hereby instruct and direct _____ insurance company to pay by check made out and mailed to:

In my/this current policy prohibits direct payment to doctor/therapist, I herby also instruct and direct you to make out the check to me and mail it to the above address for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

This is a 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. (Check each box and sign at the bottom)

- ☐ A Photocopy of this Assignment shall be considered as effective and valid as the original.
- ☐ I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- ☐ I authorize the use of this signature on all insurance submissions.
- ☐ I authorize Life Fitness Therapy to deposit checks made in my name.
- ☐ I authorize Life Fitness Therapy to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- ☐ I understand that I am financially responsible for all charges whether or not paid by insurance.

Date this ____ day of _____, 20____

_____	_____	_____
Signature of Policy Holder	Witness	Signature of Claimant, if other than Policy holder

FOR OFFICE USE ONLY

Insurance Company: _____ **Effective:** _____

Member ID: _____**Group:** _____

Contact Name: _____ **Phone #:** _____

	In	**Out**
Deductible	_____	_____
Co-Pay	_____	_____
YTD MET	_____	_____
Insurance %	_____	_____
Co-Insurance	_____	_____
OOP	_____	_____
YTD MET	_____	_____
LIFE TIME MAX	_____	

Pre-Cert Authorization **Yes** **No** **#** _____

Reference # _____

Initials: _____