

ASSIGNMENT OF BENEFITS

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1. PATIENT'S NAME AND ADDRESS	2. DATE OF BIRTH
	3. POLICY NUMBER
4. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN FOR SERVICE DESCRIBED BELOW.	
DATE: _____ SIGNED: _____	

PHYSICIAN'S STATEMENT

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1. DATE OF ILLNESS (FIRST SYMPTOM), INJURY (ACCIDENT OR PREGNANCY (LMP))	2. DATE FIRST CONSULTED FOR THIS CONDITION	3. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? <input type="checkbox"/> Yes <input type="checkbox"/> No				
4. DATE PATIENT ABLE TO RETURN TO WORK	5. DATES OF TOTAL DISABILITY FROM _____ THROUGH _____	6. DATE OF PARTIAL DISABILITY FROM _____ THROUGH _____				
7. NAME OF REFERRING PHYSICIAN	8. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____					
9. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (if other than home or office)		10. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? <input type="checkbox"/> Yes <input type="checkbox"/> No				
11. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE 1. 2. 3. 4.						
12.	A DATE OF SERVICE	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS
13. SIGNATURE OF PHYSICIAN OR SUPPLIER SIGNED _____ DATE _____			14. ACCEPT ASSIGNMENT? (GOVERNMENT CLAIMS ONLY) <input type="checkbox"/> Yes <input type="checkbox"/> No	15. TOTAL CHARGE	16. AMOUNT PAID	17. BALANCE DUE
20. YOUR PATIENT'S ACCOUNT NO.			18. YOUR SOCIAL SECURITY NO.	19. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.		
21. YOUR EMPLOYER I.D. NO.						

5043-73-73 8/04

PLEASE DETACH AND MAINTAIN FOR YOUR RECORDS

DATE CLAIM MAILED:

CHARGES SUBMITTED:

PROVIDER

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