

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: _____