ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE
-ASIGNACION DE BENEFICIOS-

Patient:_____

Insured:_____

SS/ID #:_____

Address:_____

Phone:_____

Insurance Name:_____

Group #_____

I hereby instruct and direct my dental insurance plan to pay by check made out to the name of my attending dentist, Dr.

(Nombre del Dentista),

and mailed directly to his/her billing address at: 4364 Bonita Road # 233, Bonita, CA 91902- for the professional expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for 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 asignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

ASIGNACION DE BENEFICIOS

Por medio de la presente autorizo a mi plan dental a que pague por cheque girado a nombre de mi dentista tratante, el doctor arriba mencionado y que se lo envie por correo, por concepto de servicios profesionales, como beneficio de mi poliza dental, que de forma ordinaria seria pagado directamente a mi. ESTA ES UNA ASIGNACION DE MIS DERECHOS Y BENEFICIOS BAJO MI POLIZA. El pago no excedera el total de mi cuenta y acepto y estoy consciente que es mi responsabilidad pagar cualquier balance que quedara pendiente y que no hubiera sido cubierto por mi aseguranza.

Signature of Policyholder_____ Date:_____
(Firma del Titular de la Poliza) (Fecha)

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Signature of Claimant, if other than policyholder:_____
(Firma del Paciente o Reclamante)