Family Medicine at Greenhill
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Assignment of Benefits

For: Patient Name: _____ DOB: _____

Insurance Company: _____

Insurance Co. Address: _____

Adjustor Name: _____

Insurance Co. Phone #: _____

Claim #: _____

Policy #: _____

Insured Name: _____

Date of Accident: _____ Type: ☐ Auto

☐ Personal Injury

I AUTHORIZE AND REQUEST YOUR COMPANY TO PAY DIRECTLY TO FAMILY MEDICINE AT GREENHILL, THE AMOUNT DUE IN THE PENDING CLAIM BASIC MEDICAL, MAJOR MEDICAL, AND/OR SURGICAL TREATMENT RENDERED TO:

Patient Name & SSN#: _____

Signature of Patient: _____

Witness: _____