813 Eastgate Drive
Mount Laurel, NJ 08054
856-273-6400
Fax 856-273-0506

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO PROVIDER PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

PATIENT: ____

EMPLOYER: ____

CLAIM/GROUP #'S: ____

S.S.#/I.D.#: ____

I hereby instruct and direct that______________________________ insurance company send to and make the check payable to:

ALLIED ORTHOTICS & PROSTHETICS
813 EASTGATE DRIVE MT.
LAUREL, NJ 08054

Or

If my current policy prohibits direct payment to provider, then I hereby instruct and direct you to make out the check to me with the understanding that I will forward all payments owed to Allied Orthotics & Prosthetics.

The professional or medical expense benefits allowed under my current insurance policy are to be used 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 assignee, and I have agreed to pay, in a timely 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.

DATE:____

SIGNATURE OF POLICY HOLDER: X______________________________

WITNESS:____

SIGNATURE OF CLAIMANT IF OTHER THAN POLICY HOLDER:

X____