Clear Form

ANDREWS CENTER

LIFETIME ASSIGNMENT OF INSURANCE BENEFITS

NAME: _____

CHART NUMBER: _____

In consideration of hospital or center services rendered or to be rendered, I hereby irrevocably assign and transfer to the Andrews Center, Tyler, Texas, all monies due or to become due or payable to me under my insurance company, Medicaid, Medicare, or other third party payor.

I authorize Andrews Center to contact my insurance company and/or my employer for the purpose of insurance verification.

I also authorize release of medication information necessary to process claims to my payor, its agents, and/or employer.

I will not be billed for services billable to Medicaid. I will not be billed for services billable to Medicare in excess of the co-pay and deductible. I will be responsible for any non-billable services.

A photostatic copy of this authorization shall be as effective and valid as the original.

SIGNATURE: _____ DATE: _____
Insured or Authorized Person

SIGNATURE OF WITNESS: _____

MEDICAID NUMBER: _____

MEDICARE NUMBER: _____