Assignment of Benefits to “Pros In Rehab”

NOTE: All information must be **completed** or we will NOT be able to do the courtesy of dealing directly with your insurance plan.

Patient Name:________________________________ DOB________ ID #_______________________

Insurance Policy #:____

Insured Name:_______________________________Insured Date of Birth___________________________

Your relationship to the Insured: ☐ Parent ☐ Spouse ☐ Self

Benefit Information:

What is your deductible amount? $_____ and Coinsurance %______ (for the services you are seeking) *If you don’t know this information, call the “800” number on your insurance card.*

If you have a coinsurance or unmet deductible give your credit card info here. Nothing will be charged unless a balance due. Coinsurance amounts will be charged to this credit card per your benefits.

Credit Card Type: ________________ Exp. Date____________ Card #:____________________________

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I hereby instruct and direct ____________________ insurance company to pay by check made out and mailed to:

Pros In Rehab
1101 S Winchester Blvd
Suite L-237
San Jose, CA 95128

If my/this current policy prohibits direct payment to provider, I hereby also instruct and direct you to make out the check to me and **mail it to the above address** for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the 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 current manner, any balance of said professional service charges over and above this insurance payment.

(Check each box and sign at the bottom)

- ☐ A photocopy of this Assignment shall be considered as effective and valid as the original.
- ☐ I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- ☐ I authorize the use of this signature on all insurance submissions.
- ☐ I authorize Pros In Rehab to deposit checks made in my name.
- ☐ I authorize Pros In Rehab to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- ☐ I understand that I am financially responsible for all charges whether or not paid by insurance.

Dated this ______ day of ______________, 20_____.

___________________________________ ______________________________

Signature of Policyholder Witness

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Signature of Claimant, if other than Policyholder

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