Insurance Information / Assignment of My Benefits

IMPORTANT: All information must be **completed,** or we will NOT be able to do the courtesy of dealing directly with your insurance plan(s)

Insurance Info

*All information must be filled out to file insurance

Primary Insurance Name _____

ID Number_____**Group #**_____

Subscriber Name _____**Date of Birth**_____ **Relationship to Subscriber** _____

Secondary Insurance Name _____

ID Number_____**Group #**_____

Subscriber Name _____**Date of Birth**_____ **Relationship to Subscriber** _____

I hereby instruct and direct my insurance company(s) to pay by check made out to the "Healthcare Provider" **Professional Rehabilitation Services** and mailed to **P.O. Box 2397 Pawleys Island, SC.** If my/this current policy(s) allows direct payment to office / doctor / therapist.

If my/this current policy(s) prohibits direct payment to office/ doctor / therapist I understand that the insurance may directly pay me for the services. I understand I will need to bring the check(s) and Explanation of benefits to the office for it to be applied to my account. I will sign the check over to PRS and provide an Explanation of Benefits. If I do not, I understand I will be responsible for the full charges as PRS will not be paid directly and have any insurance information or payment to apply to my account if paid directly to me.

This is a direct assignment of my rights and benefits under this policy.

The below statements allow us to file your insurance as a courtesy to deal directly with your insurance(s). It allows us to also do the following listed and for any insurance problems. If any questions, please ask front desk.

(Check each box and sign at the bottom)

☐ A photocopy of this Assignment shall be considered as effective and valid as the original to submit the insurance claim on your behalf.

☐ 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 for PRS to get paid for my services.

☐ I authorize the "Healthcare Provider" named above to deposit checks made in my name in the event I bring check that was made out to me for services provided.

☐ I authorize the "Healthcare Provider" named above to initiate a complaint to the Insurance Commissioner for any reason on my behalf to help get a denial / problem resolved. (not guaranteed).

☐ I understand that I am financially responsible for all charges whether paid by insurance. Insurance is only an estimate based on what is told upon verification. I understand I should contact my insurance to check on my own physical therapy benefit and limitations.

Dated this_____day of_____, 20_____

_____ _____

Signature of Policyholder Signature of Claimant, if other than Policyholder

_____

Witness (office FD staff)