BENNETT PEDIATRICS, LLC
Phone: 352.404.7728
Fax: 352.404.7724
425 Citrus Tower Blvd Ste 104
Clermont, FL 34711-6532
www.BennettPediatrics.com

Bennett PEDIATRICS
CARING FOR THE CHILD. CARING FOR THE FAMILY.

ASSIGNMENT OF BENEFITS FORM

Date: ____/_____/ _____

Patient: _____ Parent/Guardian: _____
(PRINT NAME) (PRINT NAME)

Claim Group: _____ SS #/ID #: _____

I hereby instruct and direct _____ to pay by Electronic Funds Transfer (EFT) made out and mailed to:
(INSURANCE COMPANY)

BENNETT PEDIATRICS, LLC
365 Citrus Tower Blvd Ste 104
Clermont, FL 34711-6532

OR

If my current policy prohibits payment directly to a doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

BENNETT PEDIATRICS, LLC
365 Citrus Tower Blvd Ste 104
Clermont, FL 34711-6532

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 services charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

I authorize doctor to initiate a complaint to Insurance Commissioner for any reason on my behalf.

Signed: _____ Relationship to Patient: _____

Date: _____/_____/____ Witness: _____