PULMONARY & CRITICAL CARE ASSOCIATES ASSIGNMENT OF INSURANCE BENEFITS

(Please Print)

| Name: | | Date of Birth: | |
|--|--|--|------------------------------------|
| ASSI | GNMENT OF INSURANCE | BENEFITS: | |
| The undersigned hereby authorizes the release dependents. I further expressly agree and ack benefits, for services rendered or for services to myself and/or dependents, and that I will be bo | nowledge that my signature on this on the control of the control o | locument authorizes my physician to su signature on each and every claim to be | bmit claims for e submitted for |
| | | | |
| (Name of Insured) | hereby authorize(I | Name of Insurance Company) | to pay and |
| ereby assign directly to Pulmonary & Critical (n the attached forms. I understand I am finan hen received by and paid to Pulmonary & Crit | Care Associates all benefits, if any, o | therwise payable to me for his/her servi ırred. I further acknowledge that any in | ces as describ |
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