

ASSIGNMENT OF BENEFITS FORM

Patient Name: _____

I hereby authorize the release of any medical and other information necessary to insurance companies or associations, employee groups, government agencies or their third party payers and their agents/employees, adjusters and/or attorney's involved in my case, either electronically, by mail, fax or courier, as pertaining to my care in order to process my claims.

I also hereby authorize payment of medical / hospital benefits provided to me and submitted to my insurance company(ies) on my behalf to be paid directly to Northwest Oncology & Hematology, S.C.

If my insurance policy prohibits direct payment to doctor, I hereby instruct and direct my insurance company to do the following for any allowable benefit amounts billed by Northwest Oncology & Hematology and submitted on my behalf: Make the benefit check payable to "my name," and mail it to attention of my name "in care of," to the address as follows:

**c/o Northwest Oncology and Hematology, S.C.
3701 Algonquin Road, Suite 900
Rolling Meadows, IL 60008**

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

A photocopy of this Assignment shall be considered as effective and valid as the original.

Signature of Policyholder

Date

Signature of Claimant (if other than Policyholder)

Witness Signature