OBGYNASSOCIATES

OB-GYN Associates P.C.
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To: All Patients

Please complete the form below:

Name of Insured ____

Health Insurance ID# ____

I request that payment of authorized insurance benefits be made on behalf to Dr.____________________ for services rendered to me by my provider. I also authorize that my medical information be released to Health Care Financing Administration, and its agents, to determine benefits payable for related services.

Patients Signature ______________________________

Date ______________________________

Providers Signature ______________________________

Date ______________________________