Mark E. Richey, M.D., P.C.

Obstetrics & Gynecology
1200 Airport Heights Drive, Suite 205
Anchorage, AK 99508
Phone: (907) 272-4443 Fax: (907) 272-2262

ASSIGNMENT OF BENEFITS

Date: _____

Patient Name: _____ Date of Birth: _____

Policy Holder's Employer: _____

Policy Holder's Date of Birth: _____ Relationship to Patient: _____

I hereby instruct and direct _____ insurance company to pay by check, made out and mailed to Mark E. Richey, M.D., P.C. PO Box 202198, Anchorage, AK 99520.

If my current policy prohibits direct payment to the provider of service, I hereby also instruct and direct _____ insurance company to make out and mail the check to me and I will write a check for the same amount to Dr. Richey and mail it as follows: Mark E. Richey, M.D., P.C. PO Box 202198, Anchorage, AK 99520 for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment towards 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 service charges over and above this received on my account when made out to me.

I authorize Dr. Mark E. Richey to make a deposit into the account of Dr. Mark E. Richey on my behalf.

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 Dr. Mark E. Richey to initiate a complaint to the Insurance Commissioner on my behalf.

_____ _____
Signature of Policy Holder/Patient Date

_____ _____
Witness/Office Staff Date