Blue Cross/Blue Shield Patients Only

Please complete this form

(Need this information to complete claim forms)

Patient name: _____ Date of Birth:_____

Address: _____

Insured name: _____

Relationship to Insured? Self _____ Spouse _____ Child _____ Other _____

Insured DOB: _____ Insured SS# _____

Insured's Employer or School Name: _____

Insured Policy/ID Number: _____

Group Name/or number: _____

Referring Provider: _____

Any other insurance coverage? YES NO

If yes:

Insured name: _____Date of Birth: _____

Insured SS# _____

Insured's Employer or School Name: _____

Insured Policy/ID Number: _____

Group Name/or number: _____

Please note that the coverage for physical therapy varies.

It is your responsibility to know what your coverage is (deductible, co pay, etc.)

When Explanation of Benefits are received by HOPE Center for Pain, you will be billed for your portion not covered by insurance.

HOPE Center for Pain
Assignment and Instruction for Direct Payment to Physical Therapist

I hereby direct and instruct Blue Cross and Blue Shield of Illinois Insurance Company to pay by check made out and mailed directly to:

Leann M. Croft, MSPT, CIDN
HOPE Center for Pain
3601 General Electric Road, Suite 5
Bloomington, IL 61704

For any professional or medical expense benefits payable to me under my current policy.
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 insurance payment.

IF MY CURRENT POLICY PROHIBITS DIRECT PAYMENT TO DOCTOR, THEN I HEREBY ALSO DIRECT AND INSTRUCT YOU TO MAKE OUT THE CHECK AND MAIL IT AS FOLLOWS:

Patient's Name: _____
C/O: Leann M. Croft MSPT, CIDN
HOPE Center for Pain
3601 General Electric Road, Suite 5
Bloomington, IL 61704

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Dated: _____

_____ _____
Signature of Policyholder Witness
Or Claimant, if other than policy holder

OFFICIAL NOTIFICATION -
A PHOTOCOPY OF THIS ASSIGNEMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS ORIGINAL.