



7 Lakeland Circle
Suite 500
Jackson, MS 39216

Phone: 601-203-2906

ASSIGNMENT OF BENEFITS FORM

Name of Insured (printed) _____

Social Security Number: _____

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Zoviellles Family Medical and Behavioral Health Care, LLC . for any medical services provided to me by that organization. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related medical services to the organization, my insurance carrier, or other medical entity. A copy of this authorization may be sent to the Centers of Medicare and Medicaid Services, my insurance company or other entity, if requested. The original will be kept on file by the organization. I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for services received.

_____ Patient Name (Printed)

_____ Relationship to Insured

_____ Signature of Insured/POA

_____ Date