

QUINCE ORCHARD
MEDICAL CENTER

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

PATIENT NAME: _____
EMPLOYER: _____
DATE OF INJURY: _____
CLAIM #/GROUP #: _____
SS #/ID #: _____

I hereby instruct and direct the _____ Insurance Company to pay by check made out to and mailed directly to:

Quince Orchard Medical Center
14800 Physicians Lane #231
Rockville, MD 20850

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

c/o Quince Orchard Medical Center
14800 Physicians Lane #231
Rockville, MD 20850

for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THE 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 fees for non-covered services and/or fees over and above the insurance payment or as required by my insurance policy.

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 claim.

Dated at Montgomery County, this _____ day of _____, _____
Day Month Year

Signature of Policyholder

Witness

Signature of Claimant, if other than Policyholder