

INSURANCE VERIFICATION REQUEST FORM

and

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

<b>Larry Han, LAc</b> <b>904-234-2023</b>	<b>Insurance Verification Request Form</b>
Patient Name	
Date of Birth	
Patient Phone #	
Insurance Company	
ID#	
Group #	
Provider Phone # on back of card	
Acupuncturist	
Date of Appointment	
Remarks	

# ACUPUNCTURE TREATMENT CENTER

Larry L. Han LAc  
1700 Wells Road Suite 28 Orange Park, Florida 32073  
TELEPHONE: 904-234-2023 FAX: 407-888-8211

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## **ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR**

PATIENT NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_ ZIP \_\_\_\_\_

EMPLOYER/INSURANCE \_\_\_\_\_

GROUP # \_\_\_\_\_ ID# \_\_\_\_\_

I HEREBY INSTRUCT THE ABOVE NAMED INSURANCE COMPANY TO PAY BY CHECK MADE OUT TO AND MAILED DIRECTLY TO:

**Larry L. Han Inc. DBA  
Acupuncture Treatment Center  
1700 Wells Road Suite 28  
Orange Park, FL 32073**

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

**C/O Larry L. Han Inc. DBA  
Acupuncture Treatment Center  
1700 Wells Road Suite 28  
Orange Park, FL 32073**

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 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 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 FOR THE PURPOSE OF SECURING PAYMENT UNDER THIS POLICY OF INSURANCE.

DATED AT \_\_\_\_\_ COUNTY, THIS \_\_\_\_\_ DAY OF \_\_\_\_\_ 20\_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF POLICY HOLDER

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
SIGNATURE OF CLAIMANT, IF OTHER THAN POLICYHOLDER

\_\_\_\_\_  
RELATIONSHIP TO PATIENT