I hearby assign benefits payable from this claim and authorize payment directly to their office.

I understand that the fees listed in this claim may not be covered by or may exceed my plan benefits. I understand that I am financially responsible to my provider for the entire treatment. I acknowledge that the total fee of $_____ is accurate and has been charged to me for services rendered. I authorize release of the information contained in this claim form to my insuring company/plan administrator.

_____

Provider Name (name of business payment is to be directed to)

_____

Signature of Patient (parent/guardian)

_____

Member/Certificate Name (please print)

ProBenefits Inc.

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