Jigish Patel M.D./ Keith Welch ARNP/ Candis Welch ARNP
3228 E. 15th Street
Panama City, Fl. 32405
(850)628-2113

AUTHORIZATION ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare and/or Medical insurance benefits be either made to me or on my behalf for any services furnished me by Jigish Patel M.D.

I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

I request that payment of authorized secondary benefits be made on my behalf to Jigish Patel M.D. for any services furnished me by Jigish Patel M.D./Keith Welch ARNP. I authorize any holder of medical information about me to release to any of my insurance companies any information needed to determine these benefits or the benefits payable for related services.

I hereby authorize payment directly to Jigish Patel M.D. Of benefits otherwise payable to me. I understand and agree that any unpaid balance not covered by this policy will be payable by me.

Signed:______________________ Date: ___/___/___
(Beneficiary)

Health Ins. Plan #:______________________________

Medigap Policy #_______________________________