Aiken Dermatology and Skin Cancer Clinic, PA

Assignment of Benefits Form

I authorize the submission of insurance claims by Aiken Dermatology and Skin Cancer Clinic, PA and request that payment of authorized insurance benefits, including Medicare plan payments (if I am a Medicare beneficiary), be made on my behalf to Aiken Dermatology and Skin Cancer Clinic, PA for any services rendered to me.

I authorize the release of any medical or other information necessary by Aiken Dermatology, my insurance carrier, CMS, or other entities, as applicable, for benefits determination and claims payment. A copy of this authorization will be sent to CMS, my insurance carrier, or other applicable entities in accordance with Federal or State law, if requested. The original authorization will be kept on file by Aiken Dermatology and Skin Cancer Clinic, PA.

I authorize the use of my signature on all insurance submissions.

I understand that I am financially responsible for any Member portion (copay, coinsurance, deductible, payment in full for non-covered services), as applicable.

Patient's Name: _____

_____

Signature of Beneficiary/Responsible Party

_____

Date