KHUBCHANDANI, STASIK, BUB
1275 South Cedar Crest Boulevard
Allentown, PA 18103

PATIENT'S NAME _____

ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL INFORMATION

In order to submit a claim for payment to us for services covered under your policy, we must have your authorization.

MEDICARE AND MEDIGAP

I request that payment of authorized Medicare/Medigap benefits be made to *KHUBCHANDANI-STASIK-ROSEN, PC OR DAVID BUB, MD, PC* for any services furnished by physicians of that group. I authorize any holder of medical information about me to release to the Health Care Financing Administration Medigap Carrier and its agents any information needed to determine these benefits or the benefits payable for related services. I hereby authorize Medicare/Medigap Carrier to furnish *KHUBCHANDANI-STASIK-ROSEN, PC OR DAVID BUB, MD, PC* any information regarding my Medicare claims under Title XVIII of the Social Security Act.

COMMERCIAL INSURANCE

I hereby authorize release of information necessary to file a claim with my insurance carrier, and I assign benefits payable to *KHUBCHANDANI-STASIK-ROSEN, PC OR DAVID BUB, MD, PC* as indicated on the claim.

I understand I am financially responsible for any balance not covered by my insurance carrier.

A copy of my signature is as valid as the original.

_____ _____

SIGNATURE DATE