

CLIENT AUTHORIZATION FOR DIRECT MEDICAL PAYMENT

Date: [Date]

To: [Insurance Company Name]

Address: [Insurance Company Address]

City, State, Zip: [City, State, Zip]

Re: Patient Name: [Patient Name]

Policy Number: [Policy Number]

Claim Number: [Claim Number (if applicable)]

Date of Service/Accident: [Date]

To Whom It May Concern,

I hereby authorize and direct [Insurance Company Name] to pay directly to [Medical Provider/Facility Name] any and all benefits due to me under my insurance policy for services rendered by said provider.

This authorization includes, but is not limited to, payments for medical evaluations, treatments, surgeries, and any other healthcare services related to the above-referenced claim or date of service.

I understand that I am financially responsible for any charges not covered by my insurance policy, including deductibles and co-payments. A photocopy or digital scan of this authorization shall be considered as effective and valid as the original.

Sincerely,

Client/Patient Signature

Print Name: [Patient Name]

Address: [Patient Address]

Phone Number: [Patient Phone Number]