Marze
D E N T A L
Brawley T. Marze, Jr. DDS
2302 North Travis St., Sherman, TX 75092
P.O. Box 910250, Sherman, TX 75091-0250
903.892.4531

Patient Name: _____ Date: _____

Assignment of Insurance Benefits

Insured's Employee Name: _____

Group #: _____ Insured's SS/ID#: _____

I hereby instruct and direct _____**Insurance Company** to pay by check made out and mailed to:

Brawley T. Marze, Jr., D.D.S., P.A.
P.O. Box 910250
Sherman, Texas 75091-0250

OR

If my current policy prohibits payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

CARE OF:
Brawley T. Marze, Jr., D.D.S., P. A.
P.O. Box 910250
Sherman, Texas 75091-0250

For the professional or medical benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, and balance of said professional service charge over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

***********RELEASE OF INFORMATION*********

I authorize the release of information pertinent to my case to any insurance company, health care provider, adjuster, collection agency or attorney involved in this case, as well as to authorize the insurance company or other health care providers to release information to Dr. Marze or his representative on my behalf.

I authorize Dr. Marze to initiate a complaint to the Insurance Commissioner, for any reason, on my behalf.

_____ _____

Signature of Patient or Guardian of Minor Date