Ambulatory Anesthesia Physicians
P.O. Box 48180
Newark, NJ 07101-4880
201-842-3993

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ SSN #: _____

Assignment of Benefits

Thank you for allowing Ambulatory Anesthesia Physicians to provide your anesthesia service. We look forward to providing you with our care. One of our complimentary services is to submit insurance and billing claims for you, easing your paperwork burden. In order for us to provide you with this service, please sign this Assignment of Benefits form.

I understand that signing this form authorizes:

> Ambulatory Anesthesia Physicians to submit claims on my behalf directly to my insurance carrier. Ambulatory Anesthesia Physicians will receive direct payment from my insurance carrier.

Patient signature: _____ Date: _____

If someone other than the beneficiary is signing this form, please complete the following information for the person signing the form: