

**REQUEST FOR ASSIGNMENT OF
BENEFITS TO HEALTH CARE PROVIDER**

Name of Patient: _____

Name of Insured
*(if different
from patient):* _____

Insurance Company: _____

Health Care Provider: _____

I am entitled to benefits under a policy of insurance written by the above insurance company. I have received treatment for an injury from the above health care provider.

As allowed by T.C.A. §56-7-120, I hereby assign to the above health care provider, from the benefits to which I am entitled, a sum of money sufficient to cover the charges of that health care provider for the services I have received. I hereby request that the above insurance company pay that money directly to the health care provider.

I understand that the amount which is paid to the above health care provider may be limited by the amounts owed to other health care providers who have provided services to me for the same injury and by the amount of medical benefits to which I am entitled under the policy. I also understand that the amount paid to the above health care provider may be deducted from any "bodily injury" award that I may receive.

If the above insurance company does not permit the assignment of benefits, I hereby request that the company disburse the sums to which I am entitled in the form of a check issued in the names of the insured and the above health care provider as joint payees and sent to the office of the provider.

I understand that if the benefits available to me under the policy are insufficient to cover the charges of the above health care provider, I am responsible for paying that portion of the provider's charges not covered by insurance.

I agree to give a 30 day notification in writing to the above health care provider before changing this assignment of benefits in any way.

Patient

Date: _____

Witness