

**Timothy J. Johans, MD**

**Patient Name:** \_\_\_\_\_

**Assignment of Insurance Benefits**

I authorize payment of medical benefits and or government benefits to the party who accepts assignment. I authorize payment of medical benefits to the undersigned physician or supplier for services preformed.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Medicare Patients only**

**Medigap Authorization**

Medicare #: \_\_\_\_\_

I request that payment that payment of authorized Medigap benefits be a made either to me or on my behalf to \_\_\_\_\_ for an services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to my designated insurer any information needed to determine these benefits or the benefits payable for related services.

Signature of Beneficiary \_\_\_\_\_ Date: \_\_\_\_\_

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