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

Patient Name:			
Address:			
City:		Zip:	<u> </u>
Phone: ()	SSN #:		,,, <u>,</u> ,
Assign	nment of Benefits		•
Thank you for allowing Ambulatory Anesthesia forward to providing you with our care. One of billing claims for you, easing your paperwork to please sign this Assignment of Benefits form.	our complimentary service	ces is to submit insuran	ce and
I understand that signing this form authorizes:			,
Ambulatory Anesthesia Physicians to s carrier. Ambulatory Anesthesia Physici carrier.	submit claims on my beha ans will receive direct pa	alf directly to my insurar ayment from my insurar	ice
Patient signature:	Dat	e:	
If someone other than the beneficiary is signithe person signing the form:	ing this form, please com	plete the following infor	mation for