INSURANCE PAYMENT ORDER

INSURANCE COMPANY NAME: _____

ADDRESS: _____

I authorize the release of any medical information necessary to process my claims. I authorize you to pay benefits due me out of indemnity under the terms of the policy issued by your company directly to the provider. I understand that services provided by BHSI not covered by my policy will be billed directly to me.

BEHAVIORAL HEALTH SERVICES
TAX ID # 56-2460669

BUSINESS OFFICE ADDRESS
2497 - 7TH AVE. E. SUITE 101
N. ST. PAUL, MN 55109

Payment is authorized upon your receipt of this property executed claim form for services rendered to me. This policy was in full force and effective at the time that these services were rendered. Payment of this account as herein directed, in whole or part, shall be considered the same as if paid, by your company directly to me. I understand that I am financially responsible to the provider for services not covered by this authorization or by services not covered by my policy. Over-payments will be returned after all insurance payments are received. If there is more than one account for a responsible party, a refund will be used to pay the other account if a balance is due. Refunds under $5 are not made unless requested. Failure to fulfill my financial obligation may result in my account being forwarded to an agency for collection. The provider accepts no responsibility for settlement of a dispute between insurance carrier and insured.

GROUP# _____

POLICYHOLDER _____ POLICY# _____

ADDRESS _____

CLIENT SIGNATURE _____ DATE _____

X15141 (01/20)