RESCISSION OF ATTORNEY ASSIGNMENT OF BENEFITS

PATIENT: ____

INSURED: ____

DATE OF INJURY:_______________________________________

CLAIM # // POLICY #: __________________________________

SOCIAL SECURITY #:____________________________________

I, being the insured on this policy, specifically direct you, my insurance company to rescind and cancel any assignment given to you by any third party including my attorney, **EXCEPT** to my **Physician**:

NAME: ______________________________

ADDRESS:____________________________

As the owner and beneficiary of this policy, I further direct that reimbursement for **ALL** services be paid **DIRECTLY** to my Physician, the provider of services under the terms of my contract of my medical bills, except the treating physician for the remainder of this claim.

Thank you for your cooperation in this matter.

I have read the information on this form. It has been fully explained to me and all of my questions about this form have been answered. I understand its contents.

I have read and agree to the above

______________________________________ ________________

Patient's Signature (If 12 years of age or older) **Signature Date**

______________________________________ ________________

Signature of Patient's Representative **Signature Date**