Bahama Health
FEEL GOOD ABOUT YOUR HEALTHPLAN

ASSIGNMENT OF BENEFITS

I hereby authorize BahamaHealth to pay Surgical and/or Medical benefits for services provided. In addition, I authorize release of all Medical Records to my insurance company if requested for the review of my claim.

NAME OF SERVICE PROVIDER: _____

DATE OF SERVICE: _____

AMOUNT PAID BY PATIENT: _____

PATIENT OR AUTHORIZED PERSON'S NAME: _____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE: _____

DATE SIGNED: _____