Complete **REHAB & SPORT**
A Division of CRS Homebased Physical Therapy, P.C.
672 South Country Road, East Patchogue, NY 11772
631.654.5282 fax 631.654.5253

Assignment of Benefits

Name of Patient_____
HICN:_____

I request the payment of authorized Medicare benefits be made either to me or on my behalf to **CRS Homebased Physical Therapy, P. C.** *for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.*

Patient Signature_____**Date**_____

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the provider of service for any services furnished to me by the provider for service. I authorize any holder of Medicare information about me to release to my Medigap insurance any information needed to determine these benefits payable for related services.

Patient Signature_____**Date**_____