**Insurance Authorization and Assignment of Benefits**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ),

 *Client Name DMH Client ID#*

hereby authorize [AGENCY NAME] to release the information requested on the attached insurance claim form.

**Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby assign and authorize payment of all benefits directly to the [AGENCY NAME].

**Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notice to Insurer:**

*Please make all checks payable to the* [**AGENCY NAME]** *and mail to*:

[Agency Name]

[Street Address 1]

[Street Address 2]

[City], CA [ZIP code]

**Federal Tax I.D. Number: [Agency Tax ID]**

For inquiries, contact the [Agency Billing Office]

* E-mail: [Billing Office/Contact e-mail]
* Phone: [Billing Office phone number]