

**CLINTON SERVICE UNIT**  
**ASSIGNMENT OF BENEFITS (A.O.B.) AND AUTHORIZATION TO BILL**

I have requested services from the Clinton Service Unit on behalf of myself and/or my dependents. I hereby assign all benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) or other benefits plan, to issue payment directly the Clinton Service Unit which includes Clinton Indian Health Center, El Reno Indian Health Center and Watonga Indian Health Center for services rendered to myself and/or my dependents regardless of my/our insurance benefits.

**Authorization to Release Information**

I have requested services from the Clinton Service Unit on behalf of myself and/or my dependents. I hereby authorize the Clinton Service Unit to (1) release any information necessary to insurance carriers regarding the services rendered; (2) process insurance claims generated in the course of services rendered; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

Patient Name \_\_\_\_\_ Signature: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Date: \_\_\_\_\_  
Health Record Number: \_\_\_\_\_ D.O.B.: \_\_\_\_\_  
Name of Insurance: \_\_\_\_\_  
Legal name of policy holder (if different than patient): \_\_\_\_\_  
Policy Identification Number: \_\_\_\_\_  
Group Identification Number: \_\_\_\_\_  
Policy Holder Name of Employer: \_\_\_\_\_

Next, please check below which benefits the above policy provides. Otherwise, please complete a separate **A.O.B. and Authorization to Bill** form for each policy.

Medical                  Dental                  Vision                  Pharmacy                  Behavioral Health

Names of dependents, including spouse, covered by policy and dates of birth:

1. \_\_\_\_\_ D.O.B.: \_\_\_\_\_
2. \_\_\_\_\_ D.O.B.: \_\_\_\_\_
3. \_\_\_\_\_ D.O.B.: \_\_\_\_\_
4. \_\_\_\_\_ D.O.B.: \_\_\_\_\_
5. \_\_\_\_\_ D.O.B.: \_\_\_\_\_