SKIRBALL HOSPICE

# ASSIGNMENT OF BENEFITS

I hereby authorize □ Medicare □ Medi-Cal □ Other _____
**Name of Insurance Co.**

To pay directly to Skirball Hospice for _____ any insurance or government benefits to which I may be entitled under terms of my insurance coverage with the above mentioned insurance carrier, such amount not to exceed the coverage for services rendered.

_____ _____
Insured Name Social Security Number

_____ _____
Insured Signature Subscriber Number

_____ _____
Representatives Signature Relationship

_____
Date

_____ _____
Hospice Representative Date

_____
Title of Hospice Representative