Radiation Oncology Associates

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PATIENT AUTHORIZATION FOR ASSIGNMENT OF BENEFITS TO RADIATION ONCOLOGY ASSOCIATES PC

I, _____, hereby authorize Radiation Oncology Associates PC to apply for benefits on my behalf for covered services rendered. I request payment from my insurance be made directly to Radiation Oncology Associates PC.

I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information for this or any related claim to my insurance company, including the Social Security Administration and Centers for Medicare and Medicaid Services (CMS) when a claim involves Medicare Part B.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either myself or Radiation Oncology Associates PC at any time in writing.

Signature of patient, guardian or subscriber Date