

Assignment of Benefits Form

Alumni Dental Center
2335 Sterlington Road Suite 200
Lexington, Ky. 40517
859-273-5556

Date _____

Insured's Name: _____

Patient: _____

Employer: _____

Claim Group: _____

SS#/ID# _____

Do you have dual coverage: YES NO

I hereby instruct and direct _____ Insurance Company to pay
by check made out and to :

Alumni Dental Center
Dr. Larry Kopczyk DMD
Dr. Brian Vieth DMD
Dr. Tim Majors DMD

Or

If my current policy prohibits direct payment to the doctor, I hereby also instruct and
direct you to make out the check to me and mail it as follows:

Alumni Dental Center
2335 Sterlington Road Ste 200
Lexington, Ky. 40517

For the professional or medical expense benefits allowable, and otherwise payable to me under my current
insurance policy as payment toward the total charges for the professional services rendered. THIS IS A
DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

A Photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster,
or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance company for any reason on my behalf.

Signature

Witness

Date

