Drs. Maklansky. Kurzban, Cohen, Zimmer, Hyman, Berson, Maklansky, Mester and Mecca
New York Medical Imaging Associates, PC
Tel: 212.535.9770 ● Fax: 212.988.1520
165 East 84th Street ● New York,NY ● 10028
www.NYMIassociates.com

ASSIGNMENT OF BENEFITS

Name of Policy Holder _____

Health Insurance Claim Number _____

I request the payment of authorized insurance benefits be made on my behalf to:

NEW YORK MEDICAL IMAGING ASSOCIATES P.C.

for any services furnished by the physician. I authorized any holder of medical information about me to release to the insurance carrier and its agents any information needed to determine these benefits or the benefits payable for related services. This authorization will be valid for all subsequent visits unless cancelled by the beneficiary.

Patient's Signature _____

Date_____

[Type text]