

**Gupta ENT Center**  
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**Assignment of Insurance Benefits and  
Identification of Primary and Secondary Insurance**

In consideration for the services received by me or my dependant on \_\_\_\_\_,  
I assign all rights I possess regarding payment for those services under federal and state statute, under  
common law and under my contract with the insurance company or companies identified below to

I also certify that my primary health insurance company and contract number is:

\_\_\_\_\_  
Insurance Company

\_\_\_\_\_  
Contract Number

Further, I certify that my second health insurance company and contract number is:

\_\_\_\_\_  
Insurance Company

\_\_\_\_\_  
Contract Number

I certify that my primary insurance company has accurate and up-to-date information regarding  
secondary insurance coverage (coordination of benefits).

Signature \_\_\_\_\_

Printed Name \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone Number: \_\_\_\_\_

Social Security Number: \_\_\_\_\_