



Assignment of benefits form for

Last Name _____ First Name _____

I, _____, Plan # _____,
ID # _____, Division # _____

Authorize 20/20 Vision Care of Medicine Hat to bill and receive payment for the provided services dated
Month _____ Day _____ Year _____

Please Send Payment To:

(Do not send payment to patient)

20/20 Vision Care
431 3rd Street S.E.
Medicine Hat, Alberta, Canada
T1A 0G8

Signed _____ Date _____



Direct Billing Disclaimer

We, at 20/20 Vision Care pride ourselves on providing the best service and ease of purchase. To continue to provide such services, as direct billing, we need you to understand that if for any reason the insurance company does not cover the full expected amount, you will be responsible for the remaining balance. This balance will need to be paid in full within 30 days from the date we notify you of the changes.

Dependant

Last Name _____ First Name _____

Policy Holder (If claiming for Dependant)

Last Name _____ First Name _____

Policy Holder Signature

Date

Month _____ Day _____ Year _____