William R. Evans, D.D.S., Inc.
16635 Centerfield Drive, Suite 205
Eagle River, AK 99577
(907) 694-5150
www.evansdentistry.net

Policyholder Printed Name:
_____D.O.B_____

Employer: _____

Group # : _____ SS# OR ID #: _____

I hereby instruct and direct _____Insurance Company to pay by check made out and mailed to:

William R. Evans, DDS, Inc.
16635 Centerfield Drive, Suite 205
Eagle River, AK 99577

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 as follows:

William R. Evans, DDS, Inc.
16635 Centerfield Drive, Suite 205
Eagle River, AK 99577

For the professional, dental 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.
This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.
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 Dr. Evans to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated on this_____ day of _____, 20_____

_____	_____
Print Name of Policyholder or Claimant, If other than Policyholder.	**Signature of Policyholder or Claimant, If other than Policyholder**

Please Print Family Members Also Covered Under This Plan:

_____	_____
_____	_____
_____	_____