

# Supplemental Health Insurance Payment Consent Form

## Policyholder Information

Full Name

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Date of Birth

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Address

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Phone Number

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Email

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Insurance Company

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Policy Number

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## Consent

☐ I authorize the direct payment of supplemental health insurance benefits to the provider for services rendered. I understand that I am financially responsible for any balance not covered by my insurance.

## Additional Information

Comments/Instructions

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Signature

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Date

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