ASSIGNMENT OF HEALTH INSURANCE

Member Name: _____

Patient Name: _____

Contract ID: _____

I authorize the MESSA Benefits Office to issue reimbursement directly to any and all providers for covered medical services for _____.

This authorization shall remain in effect until I revoke it in writing.

Please mail this form to:

MESSA Medical Case Management
1475 Kendale Blvd.
East Lansing, MI 48823

or fax it to: 517.203.2998

_____ _____
Member Signature Date

_____ _____
Witness Signature Date