



PALM BEACH ORTHOPAEDIC INSTITUTE, P.A.

WWW.PBOI.COM

RELEASE OF AUTO / P.I.P. BENEFITS

Instructions: Please fill out the top portion of this form and fax to PBOI.

I _____, hereby authorize _____ to
(Patient's full name) (Insurance Carrier)

release benefit information from my policy to **Palm Beach Orthopaedic Institute, P.A.** for insurance verification purposes.

Patient Signature: _____ Date: _____

INSURANCE CARRIER

Please complete the benefit information below and fax to Jessica at **(561) 727-1230**.

PIP benefits: _____

Medpay benefits: _____

PIP deductible: _____

Signature: _____ Date: _____

Printed Name: _____

Claim#: _____

Notes: _____
