GASTROENTEROLOGY CENTER OF NORTHERN VIRIGINIA, LTD.

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OUT-OF-NETWORK ASSIGNMENT

Name of Patient: ____

Date of Service: ____

Place of Service:

- ☐ Office
- ☐ Endoscopy facility (outpatient)

Insurance: ____

I.D. Number: ____

Reason:

- ☐ I use PPO side of my benefits
- ☐ No referral
- ☐ NO insurance or unable to verify benefits
- ☐ Other:______________________________

I understand that I am using out-of-network benefits and/or am unable to verify my benefits and am responsible for the balance of charges not covered by my insurance.

____
Patient signature

____
Date