



MRI OF WALLKILL
674 EAST MAIN STREET • MIDDLETOWN, NY 10940
(845) 344-4405 • fax (845) 344-4577
www.orangeradiology.com

Patient _____
Last Name First Name Initial

Patient Address _____
Street City State Zip

Home Telephone # _____ Male ___ Female ___ Date of Birth _____

Work # _____ Cell# _____ SS# _____

Were you referred by an attorney? ___ Yes ___ No

If yes, Attorney's Name _____ Phone _____

Primary Ins.: _____ **ID #:** _____

Secondary Ins.: _____ **ID#:** _____

Insurance Holder _____
Or Guarantor Last Name First Name Initial

Insured's Address _____
Street City State Zip

Date of Birth _____ Male ___ Female ___ SS# _____

Home Telephone# _____ Cell# _____ Work# _____

EMAIL ADDRESS _____ Fax # _____

ASSIGNMENT OF BENEFITS

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE/OTHER INSURANCE CARRIER BE MADE ON MY BEHALF TO ORANGE RADIOLOGY/MRI OF ORANGE FOR SERVICES FURNISHED TO ME BY THE PROVIDER. I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES.

PATIENT OR GUARDIAN SIGNATURE: _____

DATE _____ (Must be 18 years of age or older or signed by guardian)