INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

Client Name: _____ Client ID: _____

I hereby authorize **Didi Hirsch Mental Health Services** to release the information requested on the attached insurance claim form.

Signature: _____ Date: _____

I hereby assign and authorize payment of all benefits directly to the **Didi Hirsch Mental Health Services**.

Signature: _____

Notice to Insurer:
*Please make all checks payable to the **Didi Hirsch Mental Health Services** and mail to:*

Didi Hirsch Mental Health Services
4760 S. Sepulveda Blvd.
Culver City, CA 90230

Federal Tax I.D. Number: 95-1816023

For inquiries, contact the Business Office:

- E-mail: AElder@didihirsch.org
- Phone: (310) 751-5467