

## Authorization to Pay Provider(s) Direct

Policy Number: \_\_\_\_\_

Policy Holder: \_\_\_\_\_

In order for you to assign benefits to your health care provider(s) we must have the following Authorization signed and dated.

I hereby authorize Equitable Life & Casualty Insurance Company to forward all Benefits directly to each of my individual health care provider(s). I understand that by this Authorization my health care provider(s) will receive protected health information with any benefits paid.

Signed: \_\_\_\_\_

Dated: \_\_\_\_\_

Please Fax to the Attention of **EquiCenter** at 801-579-3765

OR Mail to: **Equitable Life & Casualty**  
**Attention EquiCenter**  
3 Triad Center  
Salt Lake City, UT 84180-1200