South Coast PHYSIOTHERAPY

Benefit Assignment Form

Instructions: This form must be filled out when claim payment is assigned to the Provider. Please retain this form in the patient's file for verification purposes for two years following closure of the patient file.

Provider: South Coast Physiotherapy

Patient: _____ **DOB:** _____

Policy Holder: _____ **DOB:** _____ ***(Do not fill in if the policy holder is the patient)***

Address: _____ **City:** _____

Postal Code: _____ **Phone Number:** _____

Insurance Company: _____

Plan Number: _____

Certificate / Identification Number: _____

I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/ or supplies provided.
I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this Assignment, that any benefit payment made in accordance with this Assignment will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.
I understand that this Assignment will apply to all eligible claims submitted electronically by the Provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator.
If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the Provider.

_____ _____ _____

Date: Signature: Print Name:

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Consent to Collect and Exchange Personal Information

Message to the Plan member, Spouse and/or Dependent regarding Personal Information
Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and/or plan abuse.

Authorization and Consent
I authorize my health care provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.

I authorize the insurer and/or administrator and their service provider(s) to:

- Use my personal information for the above purposes
- Exchange my personal information with any individual or organization, including healthcare benefits or other benefits programs when relevant for the above purposes
- Exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member
- Exchange personal information for the above purposes electronically or in any other manner

I understand that personal information may be subject to disclosure to those authorized under applicable law. I agree that a photocopy electronic version of this authorization shall be valid as the original and may remain in effect for the continued administration of the group benefits plan.

Electronic Transmission Authorization and Consent

Additional Consent Applicable to Plan Members Only
I confirm that I am authorized by my spouse and/or dependents, if any, to disclose personal information about them to the insurer and/or plan administrator and their service provider(s) for the purposes described above and I confirm that my spouse and/or dependents also authorize the insurer and/or administer and their service provider(s) to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing the group benefits plan. I also authorize my spouse/dependent to assign benefit payments under the plan to the health care provider. In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purposes of investigation and prevention or fraud and/or plan abuse. If there is any over payment, I authorize the recovery of the full amount of the over payment from any amount payable under the group benefits plan, and the exchange of personal information with other persons/organizations including credit agencies and, where applicable, my Plan Sponsor, for that purpose.

Date: _____ Print Name: _____ Signature: _____