Extended Medical Plan Billing Form

My Extended Medical Plan is with (Please check one of the following plans)

__ Sunlife	__ Manulife	__ Johnson Insurance	__ Equitable Life
__ Standard Life	__ Pacific Blue Cross	__ Maximum Benefit	__ Chambers of Commerce
__ Industrial Alliance	__ Great West Life	__ Greenshield	__ First Canadian Group

Provider: Cloverdale Physiotherapy & Sports Clinic
Address: 105B 17780 56 Avenue
City/Province: Surrey, B.C.
Postal Code: V3S 1C7
Phone Number: 604-574-4342

Patient: _____

Address/City/Province: _____ Postal Code: _____

Phone Number: _____

Plan Number: _____Certificate/Plan Member Number: _____

Area of Injury: _____

Is this plan under your name: ___ Yes ___ No

If no, Plan Member Name: _____ Plan Member Birthday: _____

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 file for verification purposes for two years following closure of the patient file.

I hereby assign benefits payable for the eligible claim 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 all 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 dependant, I confirm that I am authorized.

Signature: _____ Date: _____

Electronic Transmission Authorization and Consent Form

Instructions: This form must be filled out when claims are submitted electronically by the provider on the patient's behalf. Please retain this form in the patient's file for verification purposes for two years follow closure of the patient file.

Consent to Collect and Exchange Personal Information:
Message to the Plan Member, Spouse, and/or Dependant regarding personal Information.
Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependants, 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 healthcare 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 plan administrator and their service provider(s) to:

- Use my personal information for the above purposes.
- Exchange person information with any individual or organization including healthcare professionals, investigative agencies, insurer and reinsurers, and administrators of government 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 authorize under applicable law.
I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may retain in effect for the continued administration of the group benefits plan.

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 plan administrator 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 and/or dependents to assign benefit payments under the plan to the healthcare 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 of fraud and/or plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my Plan sponsor, for that purpose.

Signature: _____ Date: _____