GROUP23 SPORTS MEDICINE

DIRECT BILLING
BENEFIT ASSIGNMENT, ELECTRONIC TRANSMISSION AUTHORIZATION AND CONSENT FORM

This form is to be used for direct billing purposes only. If you do not have insurance, or if you do not wish to have Group23 Sports Medicine direct bill your insurance provider, please do not complete this form.

Patient Instructions: If you wish for Group23 Sports Medicine to direct bill your insurance provider, please complete the following information. Please note, not all services, purchases, and/or insurance providers are eligible for direct billing through Group23. Please see clinic signage for more information.

Please complete:

- Section 1 (a member of our team can help you if you have forgotten your provider's name)
- Sections 2, 3, and 4
- Only complete Section 5 if you are completing this form on behalf of a spouse and/or dependents
- Please sign and date at the end of this form, indicating your acceptance of the clauses herein

SECTION 1: PROVIDER INFORMATION		
Provider: Group23 Sports Medicine	**Provider Name:**	☐ **Physiotherapist** ☐ **Massage Therapist**
Section 2: PATIENT INFORMATION		
Insured Member Name:	**DOB:** *(Day-Month-Year)*	
Insurance Company:		
Plan Number:	**Certificate/Plan Member Number:**	

SECTION 3: BENEFIT ASSIGNMENT	
Initial	***Please read before initialing and signing:***
	I hereby assign the benefits payable for the eligible claims to Group23 Sports Medicine (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. If my claim(s) are declined by the insurer/plan administrator, I understand that I am 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 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 acknowledge 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.

Form continues on next page. Please complete both sides.

Staff Instructions: *This form must be filled out when claims are submitted electronically by Group23 (the "provider") on the patient's behalf. Please retain this form in the patient's file for verification purposes as per the Record Retention & Disposition Schedule, Sections 11010/11015.Once completed, this information is protected under the Health Information Action (HIA) and the Protection of Personal Information Act (PIPA).*

GROUP23 SPORTS MEDICINE

DIRECT BILLING
BENEFIT ASSIGNMENT, ELECTRONIC TRANSMISSION AUTHORIZATION AND CONSENT FORM

SECTION 4: 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 dependent(s), 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. This includes investigation of fraud and/or plan abuse.	
Authorization and Consent	
Initial	***Please read before initialing and signing:***
	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 personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other 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; and • Exchange person 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 or electronic version of this authorization shall be as valid as the original and may remain in effect for the continued administration of the group benefits plan.
SECTION 5: ADDITIONAL CONSENT APPLICABLE TO PLAN MEMBERS ONLY *(Applicable to plan members only when submitting a claim for a spouse or dependent)*	
Initial	***Please read before initialing and signing:***
	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 providers 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 benefits payments under the plan to the Provider.
	If 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.

Patient declaration: By signing below, I agree that I have read, understood, and agree to the terms outlined herein.

Signature

Name (Please Print)

Date

Staff Instructions: *This form must be filled out when claims are submitted electronically by Group23 (the "provider") on the patient's behalf. Please retain this form in the patient's file for verification purposes as per the Record Retention & Disposition Schedule, Sections 11010/11015.Once completed, this information is protected under the Health Information Action (HIA) and the Protection of Personal Information Act (PIPA).*