



## **DIRECT BILLING TO INSURANCE**

Electronic Transmission Authorization and Consent Form

This form **MUST** be filled out when claims are submitted electronically to insurance on patient's behalf.

Insurance companies we direct bill: Alberta Blue Cross, Sun Life, Manulife, Canada Life, Industrial Alliance, Desjardins, Claims Secure, Chambers of Commerce, Johnson Inc., Johnston Group Inc., First Canadian, Maximum Benefit, CINUP, Cowan, GroupHealth, Manion, Telus Adjudicare, GSM, Cooperators and Nexgen.

Patient First Name: \_\_\_\_\_ Last: \_\_\_\_\_

Patient's Date of Birth (YYYY/MM/DD): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

<p><b>Primary Insurance Company:</b> _____</p> <p>Primary Member's Name: _____</p> <p>Primary Member's DOB (YYYY/MM/DD): _____ / _____ / _____</p> <p>Primary Plan # or Policy #: _____</p> <p>Primary Member ID or Certificate #: _____</p> <p>Primary Group # (for Blue Cross only): _____</p>
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Please note, if insurance response is **PENDING**, we will follow instructions set out by your insurance company to void the claim and resubmit to be payable to the **Insured Member**. Hence, in such cases, we will collect the full visit amount up front and your insurer will pay you, the insured member, after.

Please also note that **we are unable to direct bill to your secondary insurance company**. We ask that you pay your remaining balance up and submit your receipt to your secondary insurance company after.

Provider Information (this form is used for all associated clinic locations listed below):

<b>Essence Wellness Marda Loop</b> #305, 3425 – 22 <sup>nd</sup> ST SW Calgary, AB   T2T 6S8	<b>Essence Wellness Sage Hill</b> #111, 60 Sage Hill Plaza NW Calgary, AB   T3R 0S4	<b>Essence Wellness Willow Park</b> #100, 10816 Macleod Trail SE Calgary, AB   T2J 5N8	<b>Essence Wellness Mahogany</b> #1440, 80 Mahogany Rd SE Calgary, AB   T3M 3K9
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## Consent to collect and exchange personal information

### Purpose

Personal information that we collect and disclose about you, and if applicable, is used by the insurer, and/or plan administrator of your group benefits plan, its affiliates and their service provider(s) for the purposes of assessing eligibility for your claims, underwriting, investigating, auditing and otherwise administering the group benefits plan, including the investigation of fraud and / or plan abuse and for internal data management and data analytical purposes.

### 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 such 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 programs, other organizations, or service providers working with such insurer and/or plan administrator or any of the foregoing, when relevant for the above purposes.
- where applicable exchange personal information concerning any claims with any assignee of benefits payable and 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 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.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning any 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 employer or benefit plan sponsor, for the purposes of investigation and prevention of fraud and/or benefit plan abuse. I understand that the submission of fraudulent claims is a criminal offence.

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 benefit plan sponsor, for that purpose.

If the patient is a person other than myself, I confirm that the patient has given their consent to provide their personal information for the healthcare provider and the insurer and/or plan administrator and their service provider(s) to use and disclose their personal information as set out above.

**I accept the terms and conditions (please check)**

### Benefit assignment form

I hereby assign benefits payable for the eligible claims to the healthcare provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to such provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the healthcare 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 benefit assignment form, that any benefit payment made in accordance with this benefit assignment form 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 my healthcare 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 healthcare provider.

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**Date (YYYY/MM/DD)**

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**Signature of Plan Member**