

Direct Billing - Extended Health Information

In order for us to offer you this service we will need a credit card on file as well.

In the case the billing does not go through for any reason, we will charge the credit card for the full amount and you will be responsible for submitting your receipt.

Provider: _____
Primary on Plan: _____
Primary on Birth Date: _____
Patient: _____
Date of Birth (patient): _____
City/Province: _____
Patient Postal Code: _____
Phone Number: _____
Plan Number: _____
Certificate / Plan member Number: _____

Credit card type, please circle: VISA / MC

Name on card: _____
Credit card number: _____
Expiration month/year: _____
Credit Verification Value: _____

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: