acacia health
health, through science & nature

Claim Info and Consent Form

Currently offering Direct Billing with:

Pacific Blue Cross / Great-West Life / Sun Life Financial / Manulife / Green Shield Canada
Medavie/ Johnson / Maximum Benefit / iA Financial Group/ First Canadian /Cowan / CINUP
Johnston Group/Chambers of Commerce

Services we can direct bill for: Massage Therapy, Physiotherapy, Chiropractic Care, Acupuncture and Naturopathic Care.

PATIENT INFORMATION:

First Name: _____ Last Name: _____

Date of Birth(yyyymmdd): _____ Gender: _____

PRIMARY COVERAGE INFORMATION:

Relationship to member with primary coverage (please check one): ☐ Domestic Partner ☐ Child

☐ Insured member ☐ Spouse ☐ Part Time Student ☐ Full Time Student ☐ Handicapped Dependent

Primary Member's First Name: _____ Primary Member's Last Name: _____

Primary Member's Date of Birth(yyyymmdd): _____

Insurance Company: _____ Policy #: _____ Member ID #:_____

Do you have Secondary Coverage? Y/N **We can't direct bill to Secondary Coverage plans at this time.**

ADDITIONAL CLAIM INFORMATION

Is your treatment at Acacia related to any of the following:

- Worksafe Claim Y/N If yes, what is the date of your accident: _____ Case #: _____
- ICBC or other auto insurance claim Y/N Date of accident: _____ Claim #_____
- A travel insurance claim Y/N

*Please update front staff if you start any of the above claims and we are doing direct billing for you.

NB: We can't do direct billing to Pacific Blue Cross if you've answered yes to any of the claims above.

Was this service prescribed or a referral by a physician? Y/N (This is necessary for some plans – we will need a copy)

Prescriber's First Name: _____ Last Name: _____

Please note: 1 - Not all insurance plans are set up so that payments can be sent to the clinic, in which case we can not direct bill and the client must pay for their appointment in full.

2 – Some claim submissions need additional processing by the Insurance Company in which case we are unable to direct bill for the client and they must pay for their appointment in full.

Acacia Health

Dockside Clinic
101-391 Tyee Road
Victoria, B.C., V9A 0A9
Fax. 250-590-1502

Westside Clinic
180-130 Wilson Road
Victoria, B.C., V9A 7N6
Fax. 250-590-6430

ph. 250-475-1522
www.acaciahealth.ca

Benefit Assignment and Electronic Transmission Consent Form

Instructions: This form must be filled out when:

- Claim payment is assigned to the Provider.
- 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 following closure of the patient file.

Provider: Acacia Health_____
Address: 130-180 Wilson St_____
City/Province: Victoria / BC_____
Postal Code: V9A 7N6_____
Phone Number: 250-475-1522 (ext 1)_____

Patient: _____
Address: _____
City/Province: _____
Postal Code: _____
Phone Number: _____
Plan Number: _____
Certificate / Plan member 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

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 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 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 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.

Electronic Transmission Authorization and Consent Form

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.

_____ _____

Date: Signature

_____

Print Name

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