Kanata Massage Therapy

TELUS Health

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 following closure of the patient file.

Provider/Clinic		
First and last name or clinic name: Kanata Massage Therapy		
Address 107-600 Terry Fox Drive		
City: Kanata	**Province:** Ontario	**Postal code:** K2L 4B6

Patient/Client		
Client First Name	**Client Last Name**	**Client Date of Birth**

Primary coverage insurer/payer

◯ BPA Benefit Plan Administrator	◯ Desjardins Insurance	◯ Johnson Group Inc
◯ Blue Cross (VAC/RCMP)	◯ First Canadian	◯ LUNA Local 183
◯ Canada Life (formally Great West Life)	◯ GMS Carrier 49	◯ LUNA local 50
◯ Canadian Construction Workers Union	◯ GMS Carrier 50	◯ Manion
◯ Chamber of Commerce Group Insurance	◯ GroupHEALTH	◯ Manulife
◯ CINUP	◯ GroupSource	◯ Maximum Benefit
◯ ClaimSecure	◯ Industrial Alliance	◯ Sunlife Financial
◯ Cowan	◯ Johnson Inc	◯ TELUS AdjudiCare

Primary Coverage Plan Info		
Primary Coverage Plan Member First Name	**Primary Coverage Plan Member Last Name**	**Primary Plan Member Date of Birth** (yyyy/mm/dd)

Relationship

◯ insured member ◯ spouse ◯ child ◯ handicapped dependant
◯ full time student ◯ part time student ◯ domestic partner

Primary coverage policy number (also referred to as group or contract number)

Primary coverage certificate number (also referred to as member/identification number)

(Canada Life only) secondary coverage plan member name

Is this an injury caused by an accident?		
◯ **Yes** ◯ **No**	**If yes** ◯ Motor vehicle ◯ Work place ◯ Other	**Date of Accident**

Is Massage Therapy prescribed or a referral?		
◯ **Yes** ◯ **No**	**If Yes - Doctor's First Name**	**Doctor's Last Name**

Secondary Coverage (if applicable)		
Secondary Coverage First Name	**Secondary Coverage Last Name**	**Secondary Plan Member Date of Birth (yyyy/mm/dd)**
Secondary Coverage Insurer/Payer ◯ BPA Benefit Plan Administrator ◯ Blue Cross (VAC/RCMP) ◯ Canada Life (formally Great West Life) ◯ Canadian Construction Workers Union ◯ Chamber of Commerce Group Insurance ◯ CINUP ◯ ClaimSecure ◯ Cowan	◯ Desjardins Insurance ◯ First Canadian ◯ GMS Carrier 49 ◯ GMS Carrier 50 ◯ GroupHEALTH ◯ GroupSource ◯ Industrial Alliance ◯ Johnson Inc	◯ Johnson Group Inc ◯ LUNA Local 183 ◯ LUNA local 50 ◯ Manion ◯ Manulife ◯ Maximum Benefit ◯ Sunlife Financial ◯ TELUS AdjudiCare
Secondary Coverage Relationship ◯ Insured member ◯ spouse ◯ child ◯ domestic partner ◯ full time student ◯ part time student ◯ handicapped dependant		
Secondary coverage policy number (also referred to as group or contract number)		
Secondary coverage certificate (also referred to as member/identification number)		

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

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.

☐ I accept the terms and conditions

_____ _____

Date Signature of plan member

All information contained herein is protected by privacy laws including the Personal Information Protection and Electronic Documents Act (PIPEDA) and all the corresponding provincial legislation. All users agree to protect the personal health information contained herein from unauthorized use, disclosure, loss, theft, or compromise in accordance with the above noted laws and with at least the same care employed to protect their own confidential information. Any unauthorized access, disclosure or use of this information is illegal.

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