Electronic Transmission Authorization and Consent Form

This form must be filled out when claims are submitted electronically by the provider on the patient's behalf. It will be retained in your file for verification purposes.

Provider:
North Ajax Rehab & Sports Injury Clinic
95 Magill Drive
Ajax, ON L1T 4M5
(905) 428-8811

Patient Name: _____
Primary Plan Member Name: _____
Insurance Company: _____
Plan Number: _____
Certificate / Plan Number: _____

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 submitted by our clinic to your group benefits plan for your reimbursement of assessment and treatment fees.

Authorization / Agreement

I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer 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 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 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.

Consent

I confirm that all parties involved (the patient, spouse and/or dependents, insurer, plan administrator, and service provider(s)) shall be able to disclose information for the purposes of assessing and paying a benefit.

If there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted, I agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization (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 of Plan Member / Applicable Plan Member

_____
Print Name: