# Green Shield Canada Agreement & Direct Bill Authorization

This form must be filled out when claims are submitted electronically by the provider on the patient's behalf.

Provider: _____ Patient: _____

___ Living Balance Clinic

Address: _____

585 Springbank Dr, Lower East Suite City/Province: _____

London, ON Postal code: _____

N6J 1H3 Phone Number: _____

519-601-6602 Primary Card Holder Name: _____

(exactly as it appears on the benefit card)

Green Shield number: _____-00

## Consent to collect and Exchange Personal Information

By signing this authorization form, I agree that the information provided on this form is complete and accurate. I understand that the information provided by me to Green Shield Canada and to my therapist (further referred to as "my provider") about myself and my dependents, will be used by Green Shield Canada and my provider, for claims adjudication and any other services necessary in the administration of benefits which may include the exchange of information with other parties to administer benefit claims. If applicable, I am authorized by my spouse, and/or any dependents listed on my benefit card, to disclose and receive information about them that is used for these purposes. I understand this information may be seen by the cardholder.

I give consent to my provider, to direct bill on my behalf and/or my dependents behalf to Green Shield Canada and I authorize payment directly to my provider.

**As required on the Green shield Canada claim form, answer the following:**

Do you have other group insurance coverage that may include Massage Therapy as a benefit? No Yes

If other coverage is with Green Shield Canada, indicate Green Shield number: _____-____

If you have another insurer for massage therapy (other than Green Shield Canada), you will need to bill that insurance company first, then bill Green Shield Canada for any amount not covered by your other insurer. We regret that we are unable to set up direct billing with Green shield Canada in this case. Please contact them should you have further inquiries.

Unless and until I advise Green Shield Canada and my provider otherwise, I authorize my provider to answer the above questions on my behalf, as answered above on all future direct bill submissions to Green Shield Canada. I understand that I am required to notify both green Shield and my provider prior to any future billings, should I /and or dependents insured under this plan have a change to insurance, or require Massage Therapy due to either a motor vehicle accident or a work related injury.

Should Green Shield Canada not pay my provider for any treatment or part of treatment billed on my and/or my dependents behalf, or should any amount be reversed at any time, for any reason, I agree to pay the amount owing within5 business days, upon notification of any unpaid or reversed amount.

Date: _____ Signature: _____

Print name: _____