

Benefits Assignment Form

Instructions: **This form must be filled out when claim payment is assigned to the Provider.**
Please retain this form in the patient's file for verification purposes for two years following closure of the patient file.

Provider: PhysioWorks Physiotherapy Ltd
Address: 109 – 1700 Market Street SE
City/Province: Airdrie, AB
Postal Code: T4B 0M5
Phone Number: 403-945-0227

PhysioWorks Physiotherapy Ltd
1101 401 Coopers Blvd
Airdrie, AB
T4B 4J3
587-360-0227

Patient: _____

Address: _____

City/Province: _____

Postal Code: _____

Phone Number: _____

Insurance Provider: _____

Policy Holder's Name _____

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: