MEDAVIE BLUE CROSS™

PAYMENT ASSIGNMENT FORM

*** Please ensure all areas of this form are complete, and supporting documents are attached.**

MEMBER INFORMATION

ID Number: _____ Policy Number: _____

Member Name: _____ Telephone Number: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Patient Name: _____ Date of Birth (DD/MM/YYYY): _____

MEMBER STATEMENT

I hereby assign my benefits payable from this claim to the named provider and authorize payment directly to him/her.

I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future by Medavie Blue Cross and/or Blue Cross Life Insurance Company of Canada, may be collected, used or disclosed to administer the terms of my policy or the group policy of which I am an eligible member, to recommend suitable products and services to me and to manage Blue Cross's business. Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross organizations, health care professionals or institutions, life and health insurers, government and regulatory authorities, the member of any policy under which I am a participant and other third parties when required to administer and manage the benefits outlined in the policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time, however, in some instances doing so may prevent Blue Cross from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure.

I authorize Medavie Blue Cross to collect, use and disclose my personal information as described above.

Signature of Patient: _____ Date: _____
(if under 18 years of age, the signature of member/parent/legal guardian is required)

This consent complies with federal and provincial privacy laws. For additional information regarding privacy policies at Medavie Blue Cross, visit www.medavie.bluecross.ca or call 1-800-667-4511.

PROVIDER INFORMATION

Provider Name: _____ Provider Number: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone Number: _____

The health care provider agrees that any person authorized by Medavie Blue Cross may have access to, take extracts from and make copies of any records pertaining to the services listed above, respecting the provision of services provided to a participant and the cost of those services.

Please Note: The symbol in the upper right hand corner indicates payment assignment. You will see this symbol on cards of members where assignment is an option.

Total fee for the product(s) or service(s) received: $ _____ (invoices must be attached)

Signature of Provider: _____ Date: _____

MEDAVIE BLUE CROSS ADDRESSES

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Inquiries: 1-888-588-1212

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Halifax NS B3J 3C6
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