

INSURANCE SUBMISSION APPLICATION & AUTHORIZATION

Patient ID: _____ (For Office Use)

PATIENT INFORMATION

Name (As appears on your card): _____

Date of Birth (mm/dd/yy): _____

INSURANCE INFORMATION

Primary Insurance Company: _____

Policy / Group #: _____ ID/Certificate No.: _____

Policy Holder's Name: _____

Policy Holder's DOB: _____

Secondary (Spouse) Insurance Company: _____

Policy / Group #: _____ ID/Certificate No.: _____

Policy Holder's Name: _____

Policy Holder's DOB: _____

Were you referred to this service by a medical doctor? Yes No

If Yes, Doctor's Name: _____

POLICY HOLDER INFORMATION (If different from patient):

Policy Holder's Full Name: _____

Date of Birth (mm/dd/yy): _____

Relationship to patient: _____

CONSENT TO COLLECT & EXCHANGE PERSONAL INFORMATION

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 used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and/or plan abuse.

AUTHORIZATION & CONSENT

I authorize my healthcare provider/ Physiomobility to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or administrator 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 with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs relevant for the above purposes.
- Exchange personal information concerning any claims submitted with the plan member or person acting on behalf of the plan member.
- 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.

DIRECT BILLING POLICY

I authorize Physiomobility Health Group to bill my insurance company directly. I understand that Physiomobility will bill the insurance company after the service is provided. I authorize the payment to be directly paid to Physiomobility and I will be personally liable for any outstanding balance not covered by my insurance company. I will notify Physiomobility if the payment from the insurance company is paid directly to my account. I understand that if for any reason Physiomobility Health Group does not receive payment within 30 days of the service date, I will be responsible for the payment.

I fully understand the above and agree to abide by this policy.

Patient's Name: _____

Patient/ Guardian's Signature (Printed name serves as signature): _____

Date: _____