THE STUDY
Wellness Studio

Insurance Direct Billing Agreement:

Consent to Collect and Exchange Personal Information
Regarding Insurance Benefits

Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependants, is used by the insurer and/or plan administrator and their service provider(s) for the purpose of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and/or plan abuse.

Authorization and Consent
I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.

I authorize the insurer and/or plan administrator and their service provider(s) to:

- Exchange personal information with an individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes
- Exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of 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.

Benefit Assignment
I hear by 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 and/or plan administrator to issue payment directly to the provider.

In the event my claims are declined by the insurer and/or 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 and/or plan administrator is under obligations to accept this assignment, that any benefit payment made in accordance with this assignment with discharge the insure and plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to meet the insurer and plan administrator will also be discharged of it, obligations 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 providing written notice.

If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute and assignment of benefits payments to the provider.

Full Name (Printed) _____

Signature _____ Date _____

Insurance Benefit Plan Information & Direct Billing Set Up

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Full Name (Printed) _____

Date Of Birth (MM/DD/YYYY) _____

Primary Insurance

Insurance Company _____

Insured Member _____

Relationship to Insured Member (Circle one) Self Spouse Child Other: _____

Plan/Group # _____

Member ID _____

Physicians Prescription Required? (Circle one) Yes No

Physicians Renewal Date _____

(Copy of prescription must be submitted to The Study Movement & Wellness for Medavie Blue Cross)

Notes: _____

Secondary Insurance

Insurance Company _____

Insured Member _____

Relationship to Insured Member (Circle one) Self Spouse Child Other: _____

Plan/Group # _____

Member ID _____

Physicians Prescription Required? (Circle one) Yes No

Physicians Renewal Date _____

(Copy of prescription must be submitted to The Study Movement & Wellness for Medavie Blue Cross)

Notes: _____