Redefined Health

Extended Health Care Insurance Coverage

Patient Name: _____ Your Insurance Carrier Name: _____

DOB: _____ Coverage Type: __Individual __Family

Group or Policy #: _____ Division: _____ Certificate or Employee ID #: _____

Partner/Spouse or Parent's Name: _____ Their Insurance Carrier Name: _____

Phone #: _____ Coverage Type: __Individual __Family

Group or Policy #: _____ Division: _____

Employee ID #_____DOB_____

For your benefit, please verify your insurance carrier coverage or your spouse/parent's coverage for the following services, all of which are provided by licensed health care professionals.

Please record your answers and return a copy to our office.

For Chiropractic Care:	**Your Coverage**	**Other Coverage**
What is my coverage maximum for Chiropractic per fiscal year?	_____	_____
Is there a per visit maximum amount?	_____	_____
When does my fiscal year-end begin and end? (i.e. Jan 1 – Dec 31)	_____	_____
Does my plan cover all my family members?	_____	_____
Is there a deductible?	_____	_____
For Custom Foot Orthotics and Footwear:		
What is the maximum amount allotted to my family and I for the purchase of orthotics and/or orthopedic footwear?	_____	_____
How many pairs am I allowed per fiscal year?	_____	_____
Is it yearly coverage?	_____	_____
Would I require a prescription? ____ Medical Doctor or ____ Chiropractor	_____	_____
Can the orthotics be dispensed by a Chiropractor?	_____	_____
For Medical Acupuncture:		
What is the maximum allotted to me for acupuncture?	_____	_____
Would I require a Medical Doctor's prescription?	_____	_____
Who can administer acupuncture? (Registered Acupuncturist, etc)	_____	_____
For Registered Massage Therapy:		
What is the maximum allotted to me for massage therapy per fiscal year?	_____	_____
Is there a per visit maximum amount?	_____	_____
Would I require a Medical Doctor's prescription and if yes, how long is it valid?	_____	_____

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For Naturopath:

What is the maximum allotted to me for Naturopathic care?	_____	_____
What is the per visit maximum amount?	_____	_____
When does my fiscal year end and begin? (i.e. Jan 1 – Dec 31)	_____	_____

Benefit 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: Redefined Health
10118 124 ST NW
Edmonton, AB
T5N 1P6

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

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Electronic Transmission Authorization and Consent Form

Instructions: This form must be filled out when claims are submitted electronically by the provider on the patient's behalf. Please retain this form in the patient's file for verification purposes for two years following closure of the patient file.

Provider: Redefined Health
10118 124 ST NW
Edmonton, AB
T5N 1P6

Consent to Collect and 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 provide(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 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 provide(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 when relevant for the above purposes.

. exchange personal information concerning any claims submitted with the plan member or a 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.

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Electronic Transmission Authorization and Consent Form

Additional Consent Applicable to Plan Members Only

I confirm that I am authorized by my spouse and/or dependents, if any, to disclose personal information about them to the insurer and/or plan administrator and their service provider(s) for the purposes described above and I confirm that my spouse and/or dependents also authorize the insurer and/or plan administrator and their service provider(s) to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing the group benefits plan. I also authorize my spouse and/or dependents to assign benefit payments under the plan to the healthcare provider.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purposes of investigation and prevention of fraud and/or plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor, for that purpose.

_____ _____

Date Signature