

Docere Wellness Centre
Benefit Assignment Form and Electronic Transmission Authorization

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: Docere Wellness Centre
Address: 15 – 7750 Ranchview Dr NW
City/Province: Calgary, AB
Postal Code: T3G 1Y9
Phone Number: 403-452-6262

Patient Name: _____ **Date of Birth:** _____

Address:

City/Province: _____ **Postal Code** _____

Phone Number: _____ **AHCN:** _____

Plan Number: _____ **Member Number:** _____ **Group#** _____

Name of Benefit Provider (eg. Sunlife) _____

Primary Card Holder Name _____ **Date of Birth** _____

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.

This form authorizes Docere Wellness Centre to charge through any amount that is not covered by the insurance claim on the credit card listed below. This outstanding amount will be charged and a receipt emailed to you upon receipt.

Type of Card	Credit Card Number	CVC/Expiry Date	Name on Card
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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

This form authorizes Docere Wellness Centre to put through any charges that are not covered by the insurance claim on the credit card listed above. The amount outstanding will be charged and a receipt emailed to you immediately.

Date _____ **Signature** _____ **Please Print** _____