PROVIDER RELEASE FORM AND ASSIGNMENT OF BENEFITS

SECTION 1 – Member Information

Member Name (*Last Name, First Name*):	Certificate Number:

SECTION 2 – Patient Information

Patient Name:	Date of Birth (*dd/mm/yyyy*):

SECTION 3 – Provider Section

Attention Provider - please attach an itemized INVOICE(s) to this form. ****Physicians and Hospitals* **must provide or include the diagnosis.

SECTION 4 – Member Authorization (*To be completed by member*)

I agree that I am responsible for all claims submitted under my plan and have reviewed the claim and information that is being submitted by this provider. **I certify** that my spouse and / or my dependants of minor or major age ("Dependants") have received all goods and services claimed and that the information provided is true and complete. **I authorize** Cowan Insurance Group to collect, use, maintain and disclose personal information relevant to this claim ("Information") for the purpose of group benefits plan administration, audit and the assessment, investigation and management of this online claim ("Purposes"). I am authorized by my dependants to disclose and receive their Information, for the Purposes. **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of the benefits program to collect, use, maintain and exchange this Information with each other and with Cowan Insurance Group, and or its service providers, for the Purposes. **I agree** that both monies and overpayments that I may owe to Cowan Insurance Group in accordance with the provisions of the group benefits plan with Cowan Insurance Group, and **I authorize** Cowan Insurance Group to deduct such monies from my future claims. **I understand** Cowan Insurance Group reserves the right to classify my claim submission as an overpayment, revoke online claiming privileges, and/or notify my plan sponsor should I provide false, incomplete or misleading information. **I understand** Cowan Insurance Group reserves the right to verify with my service provider the accuracy of all claims information submitted online. **I authorize** the use of my group benefit plan certificate number for the purpose of identification and administration. **I agree** a photocopy facsimile or electronic version of this authorization shall be as valid as the original. **I understand** that Cowan Insurance Group's privacy policy is available at http://www.cowangroup.ca/privacy-policy.

Date: _____ **Member signature:** _____

If the payment should be made to the provider:

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

Date: _____ **Member signature:** _____

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