

Authorization Form for Clinic/Group Billing

Arkansas Blue Cross and Blue Shield • Health Advantage • USABLE Corporation

Please check one: New Clinic or Group Add Practitioner to Existing Clinic/Group

Name of Clinic or Group _____

Date Practitioner Joined Clinic or Group (MM/DD/YYYY) _____ Clinic/Group EIN _____

Clinic/Group Provider # (If already issued) _____

National Provider Identifier # _____

Practice Location Address of Clinic/Group _____

_____ County _____

Practice Phone # for Patient Appointments _____ Practice Fax # _____

Contact Person _____ Phone # _____

Correspondence Address of Clinic/Group _____

_____ County _____

Correspondence Phone # _____ Correspondence Fax # _____

Contact Person _____ Phone # _____

Payment Name _____ Payment EIN _____

(Attach IRS verification of EIN)

Payment Address of Clinic/Group _____

_____ County _____

Payment Phone # _____ Payment Fax # _____

Contact Person _____ Phone # _____

The undersigned hereby authorizes _____ (clinic/group name) or any of its duly authorized administrators, to accept on the undersigned's behalf any assignment or direct payment for services rendered by undersigned at such clinic/group that are covered under the following contracts:

- Arkansas Blue Cross and Blue Shield Preferred Payment Plan
- USABLE Corporation Arkansas' FirstSource® PPO
- USABLE Corporation True Blue PPO
- USABLE Corporation Primary Care Network
- HMO Partners, Inc. (d/b/a Health Advantage)

This authorization applies to all moneys due under the agreements designated above, including payment for healthcare services and any risk-sharing settlements, if applicable.

The undersigned retains the right to revoke this authorization by giving 30 days prior written notice to Provider Network Operations, Attention Clinic/Group Billing Authorization. The undersigned understands and agrees that the clinic/group named above can likewise refuse to accept payment(s) authorized by this assignment. Payments for services rendered at above named clinic and due after Provider Network Operations receives the written notice of revocation of this authorization from the undersigned or refusal to accept payments from the clinic/group, shall be paid direct to undersigned, provided, however, that the following additional terms shall apply: (a) following execution of this Authorization, neither Arkansas Blue Cross and Blue Shield nor any other payer accessing the PPO or HMO networks (hereafter collectively referred to as "Payers") shall be obligated to redirect payment to any other location or recipient except upon 30 days' prior written notice; (b) Payers shall be entitled to require satisfactory proof of signatures and authority to redirect payment; (c) in the event of a dispute between clinic/group and the undersigned or between the undersigned and any other party regarding right to receipt of any payment, Payers may, in their sole discretion, either hold all payments until such Payers deem the dispute resolved, or Payers may make payment to clinic/group, in which case the undersigned agrees to look solely to clinic/group with respect to any claims for payment, and the undersigned hereby releases Payers from any liability with respect to such payments. By signing this form, the undersigned expressly agrees to the preceding terms and conditions of clinic/group billing.

_____ Provider # _____
Print Name of Individual Practitioner

Signature _____ Date _____
(Individual Practitioner- NO STAMPS OR DIGITAL SIGNATURES) (MM/DD/YYYY)