Agreement - Delegation of a Regional Health Authority

Purpose:
By completing this form, you are authorizing the Regional Health Authority (RHA) to appoint an employee to do work on your behalf; such as submit or transmit claims, authorize adjustments to incorrectly submitted claims and obtain access to the biweekly reconciliation documents that are available on Electronic Communication to Physician (ECP). The RHA will appoint an employee to perform the required function based on resource availiability. The appointed employee will be referred to as the delegate.

Instructions

Complete all relevant sections of the form. In section 1, the service provider number is commonly referred to as the personal Medicare billing number. In section 3, please ensure to list all relevant Medicare accounts that you authorize the RHA to act on your behalf, as delegate. If you wish to provide authority for all your accounts, check the box in Section 3. Section 4 must be signed and dated.

Original completed form(s) must be returned to:

Department of Health
Medicare Payments
PO Box 5100
Fredericton, NB E3B 5G8

Should you have any questions or concerns regarding the completion of this form, please contact Medicare payments by phone at (506) 453-8274 or email at DHMedPay@gnb.ca

Agreement - Delegation of a Regional Health Authority

To provide Horizon Health with authority to act on a physician's behalf with regard to Medicare Account(s) and/ or claim submissions or administration, please complete this form and return the original document to:

Department of Health
Medicare Payments
P.O. Box 5100
Fredericton, NB E3B 5G8

Section 1 - Physician Information

Last Name: _____ First Name: _____

Service Provider Number: _____

Contact Number: _____ Email: _____

Section 2 - Delegate Agreement

I, _____, authorize **Horizon Health Network** to appoint a delegate in their sole discretion to do the following activities in relation to the account(s) listed below:

- transmit/ submit claims,
- authorize adjustments and/ or recoveries to the said account(s),
- communicate with Medicare regarding information associated with the said account(s)
- request changes to the said account(s) including changes in banking information, address changes,
- view reconciliation statements pertaining to the said account(s) in ECP (Electronic Communications to Physicians).

Section 3 - Account Information

Please list below the account(s) you wish to delegate authority as described in section 2 above:

Account Number:_____ Account Name:_____

Account Number:_____ Account Name:_____

Account Number:_____ Account Name:_____

~OR~

☐ Check this box if you wish to authorize Horizon Health Network as your delegate for **ALL** current and new account(s).

Section 4 - Agreement

I hereby agree to the following:

1. I am responsible to ensure that all claim submissions are made to the appropriate account(s);
2. I authorize Medicare to make adjustments and recoveries from the account to ensure claims are accurately submitted on my behalf
3. I understand that I continue to be fully responsible for the billings and related Medicare documents.

Physician Signature: _____ Date: _____