Medicare Delegate Authorization Form

Guidelines

The purpose of this form is to allow a service provider to appoint a **delegate** to act on their behalf or to remove previously authorized delegate access. A delegate is a person other than the service provide (for example a secretary or administrative support) who is given authority by a service provider to complete certain tasks or view certain information on the service provider's behalf.

- A separate Delegate Authorization Form must be completed if a service provider wishes to appoint more than one delegate.
- To request access for a delegate, please complete this form, **PRINT**, **SIGN** and forward to:

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

NEW **Forms can be emailed to:**
dhmedpay@gnb.ca

A service provider may appoint a Regional Health Authority (RHA) as a delegate for one or all of their accounts. If you would like to know more about delegation of an RHA and if it is right for you, please contact your local RHA zone's medical staff or Medicare Payments at (506) 453-8274, option 1.

- If you have any questions or concerns about this form or about delegation, please contact Medicare Payments at (506) 453-8274, option 1 or by email at DHMEDPAY@gnb.ca.

Important: Throughout this form, fields marked with an **asterisk** (*) are required fields. These fields are important to ensure prompt and appropriate action. **Please ensure all required fields are complete in order to avoid any delays.**

Section 1 – Service Provider Information

*Last Name: *First Name:

*Service Provider Number:

*Contact Number: *Email:

Private line if available – for use by Medicare personnel only.

Section 2 – Delegate Information

*Last Name: *First Name:

*Contact Number: *Email:

*Signature:

Regional Health Authority Username: (if applicable)

Section 3 – Action and Responsibilities

By checking the **Add** box (below), you are authorizing Medicare to provide information and access to the delegate mentioned in section 2 above. By checking the **Remove** box (below) you are authorizing Medicare to remove authority for an existing delegate.

IMPORTANT

The Medicare billing account number(s) **MUST** be listed in the "Billing Account Number(s)" column for each delegated responsibility. **For example**, we will not assume that the delegate is to have ECP access (number 2) if there are only account numbers listed in submit/transmit claims (number 1).

		Action Required		
	Delegated Responsibility	**Add**	**Remove**	***Billing Account Number(s)**
1	Submit/transmit claims, communicate with NB Medicare regarding submitted claims and authorize adjustments and/or recoveries to ensure claims are accurately submitted on the physician's behalf for the said account(s).	☐	☐	1. 2. 3. 4.
2	View Biweekly Reconciliation Statements in ECP (**E**lectronic **C**ommunication to **P**hysicians) for said account(s).	☐	☐	1. 2. 3. 4.
3	Communicate with NB Medicare to authorize adjustments and/or recoveries to claims or to obtain information on payments for the said account(s). This is intended for an individual not delegated to submit claims and/or access ECP.	☐	☐	1. 2. 3. 4.
4	View my Service Provider Profile by Individual Service Code report (this is a summary of all Fee-For-Service billing accounts used by the service provider).	☐	☐	Note: Since these are summary reports, no account number needs to be listed.
5	View my Salaried Physician Shadow-Billing Profile (this is a summary of all salaried shadow-billing accounts used by the service provider).	☐	☐	

***Please provide all relevant account numbers in these columns.**

Section 4 – Agreement

I hereby agree to the following:

1. I continue to be responsible to ensure that all billings are made under the appropriate account;
2. I authorize Medicare to make adjustments and recoveries from the account(s) to ensure claims are accurately submitted on my behalf;
3. As per sections 2 and 3 above, I hereby give authority to my delegate to act on my behalf for the account(s); and
4. I understand that I continue to be fully responsible for the billings and related Medicare documents.

*Service Provider's signature: _____ *Date: _____

If this request is for an account with multiple providers, the designated lead physician of the account may sign above. Medicare must have documentation of the designation. If the group has not designated a lead physician, please have all members sign in the member's section below. If more lines are required, please use the back of the form.

	Physician Name** ***(please print)	***Physician Signature**	***Service Provider Number**
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