



Mail to: Blue Cross and Blue Shield of Florida
Provider Data Services
P.O. Box 41109
Jacksonville, FL 32203-1109
Fax to: (904) 301-1884

Billing Authorization for Professional Associations

Authorization to Make Payments (All Programs)

We authorize Blue Cross and Blue Shield of Florida, Inc. (BCBSF) to make payment to the _____ group, group number _____, Tax ID number _____, for services performed by us for patients covered under BCBSF contract or any other program for which BCBSF is the carrier or fiscal intermediary.

We understand and agree that any claim submitted to and paid by BCBSF under an individual physician practitioner provider number and which is also paid again in response to a claim from the group, will be immediately refunded to BCBSF. It is also understood and agreed that we will not hold BCBSF liable for any payment made to the group on behalf of an individual practitioner. We understand that BCBSF's payment to the group in no way changes the responsibilities of BCBSF or us under our individual participating agreement if we are participating practitioners.

Authorization for Another Party to Sign Claim Forms

I, the undersigned, hereby authorize _____ to sign my name to BCBSF and any other claim, which BCBSF may use for contractual programs for the purpose of receiving payment for services performed by me.

In Addition:

- 1 We, the undersigned, as a group of individual practitioners practicing together, agree that we are complying with the following as a prerequisite to being assigned a single provider number for billing purposes:
 - A. Our group meets the ethical standards or policies of our organized association.
 - B. Our group is registered with any state agency as may be required by law.
- 2 We agree, as a group and as individual practitioners of the group, to inform BCBSF of any and all changes made in corporate or member status ten (10) days prior to the effective date of such changes.
- 3 We, as members of the group to which the number is issued, agree to obtain and maintain authorization from each member to allow the group to bill on his/her behalf.
- 4 We understand that in the event of overpayment, the payee- our group – shall be responsible for reimbursement.
- 5 We, as members of the group to which the number is issued, agree that the group shall have the sole right to bill for all services we perform as individual members of this group. We further agree that this group will bill the program only for those services for which it has such right.

HOSPITAL BASED PHYSICIAN ATTESTATION AND CREDENTIALING STATEMENT

I certify that I am credentialed staff, working exclusively at _____

hospital(s), and that currently, I am not providing services outside of this hospital(s) setting. I will advise Blue Cross and Blue Shield of Florida/ Health Options Inc. of any changes in this arrangement.

Physicians Signature *Physician Provider Number* *Physician Name* (PLEASE PRINT OR TYPE)

Date

I certify physicians identified in Attachment 6, work exclusively at hospital facilities and are credentialed at same.

Group Administrator

Date

I certify that I am credentialed staff and working at the following _____

hospital(s), and that currently, I am additionally providing services outside of this hospital(s) setting at the following facilities:

My Blue Cross and Blue Shield of Florida/ Health Options Inc. Provider Application is attached. I will advise Blue Cross and Blue Shield of Florida/ Health Options Inc. of any changes in this arrangement.

Physicians Signature *Physician Provider Number* *Physician Name* (PLEASE PRINT OR TYPE)

Date