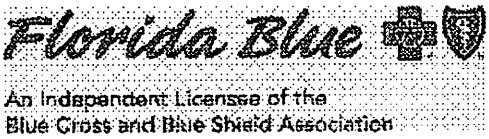

Mail to:
Florida Blue
Network Operations
P.O. Box 41009
Jacksonville, FL 32203-1109
Fax to: (904) 301-1884

Authorization to Make Payments (All Programs)

We authorize, as a group and as individual practitioners of the group, Florida Blue to make payment to the (group name)_____, **group number** _____, **Tax ID number** _____, **NPI number** _____ for services performed by us for patients covered under the group's Florida Blue contract, which is registered under the Tax ID number listed above or any other program for which Florida Blue is the carrier or fiscal intermediary.

We understand and agree that any claim submitted to, and paid by Florida Blue, under an individual practitioner provider number and which is also paid again in response to a claim from the group, will be immediately refunded to Florida Blue. It is also understood and agreed that we will not hold Florida Blue liable for any payment made to the group on behalf of an individual practitioner. We understand that Florida Blue payment to the group in no way changes the responsibilities of Florida Blue 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 that the group has authority to sign the names of health care practitioners listed herein to Florida Blue, and any other claim, which Florida Blue may use for contractual programs for the purpose of receiving payment for services performed.

In Addition:

1. We agree, as a group and as individual practitioners of the group 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 will inform Florida Blue of any and all changes to information that differs from the information reported under the terms of the current agreement, including but not limited to, Tax ID number changes, made in corporate or member status thirty (30) days prior to the effective date of such changes. Advance notification will prevent negative impacts to claims payments. Advance notice is necessary to appropriately register, credential, and associate individual practitioners to a group practice. Should we make changes to our corporate structure that includes a new Tax ID number, we will contact our Florida Blue network manager.
3. We 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 agree that the group shall have the sole right to bill for all services performed by 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.

Note: Information about each practitioner being added to the group must be completed below.

Print Name of Practitioner	Effective Date of Group Association	Provider Number	NPI

We have agreed to the above by signing below.

Note: By signing this form, the authorized individual below attests that all individual practitioners listed above within this group are aware of and agree to the information contained within this form.

*

Authorized Signature for Group _____ **Date** _____

Printed Name _____

Check one: ☐ Request for New PA Number ☐ Addition to Current Provider Group Number _____
Group Number

Group Billing Address

_____

_____

_____

Group Telephone Number _____ _____