Sooke Eyecare
Doctors of Optometry

☐ CAN WE BILL MSP ON YOUR BEHALF?

I, authorize Medical Services Plan to pay Sooke Eyecare Doctors of Optometry directly for all reimbursements for benefits payable to me under the Medical and Health Care Services Regulations care provided to me by Sooke Eyecare Doctors of Optometry. I make this assignment in full knowledge of the amount that I will be personally responsible for and the amount that is reimbursed by the MSP which will be directed to Sooke Eyecare Doctors of Optometry to be applied against any outstanding monies I owe for services provided

Name of Patient:

PHN:

☐ CAN WE CONTACT YOU BY TEXT OR EMAIL?

I hereby authorize Sooke Eyecare Doctors of Optometry to communicate with me electronically. This includes but is not limited to the co-management of my clinical file with a specialist, or the transfer of my file to another practitioner at my request.

☐ CAN WE SHARE YOUR INFORMATION WITH YOUR DOCTOR OR SPECIALIST?

I, herewith assign my benefits, payable from claims submitted electronically to Sooke Eyecare Doctors of Optometry. And authorize my insurer to send payments directly to them for all treatments.
Patient Name:
Address: ____
____
____
Phone Number: ____
Plan Member: ____ DOB:___________________
Policy: ________________________ ID: __________________ INS:______________________

I authorize my health care providers working with my insurer or plan administrator to exchange personal information when necessary for the above purposes. I understand that personal information my be subject to disclosure to those authorized under applicable law in Canada. I authorize the exchange of personal information for the above purposes to be conducted electronically or in any other manner.

Signature	Date

Practitioner Information and Declaration
Practitioner name:
MSP Practitioner Number:
MSP Payment Number: 87413
I have advised the patient that this form allows me to receive MSP reimbursement directly for services that are MSP benefits, and that patient will receive no further reimbursement from MSP. I acknowledge that all claims for services provided to this patient comply with the Medicare Protection Act and the relevant payment schedule. For each service provided, I will notify the patient of the full fee and what portion of the fee I will be claiming directly from MSP
I understand that this authorization is only valid for the remainder of the calendar year in which it is signed, and the patient and I must complete a new form for future calendar years.