

# Authorization for clinic/group billing and the Hub Apply Portal account administration access

Name of individual practitioner		NPI of individual practitioner	
Is this group one of the following: Hospitalist /Billing Group/or Emergency Services <u>ONLY</u> Yes      No			
Name of clinic or group			
Date practitioner joined clinic/group	Clinic/Group NPI		Phone
Street address of clinic/group	City	State	ZIP

The undersigned practitioner hereby authorizes the Clinic/Group named above, or any of its duly authorized administrators, to accept on the undersigned's behalf any assignment or direct payment for services rendered by undersigned at such clinic/group that are covered under the following contracts:

- Arkansas Blue Cross and Blue Shield Preferred Payment Plan
- USABLE Corporation True Blue PPO
- USABLE Corporation Arkansas' FirstSource® PPO
- HMO Partners, Inc. (d/b/a Health Advantage)
- Medi-Pak® Advantage PFFS
- Medi-Pak® Advantage LPPO
- Medi-Pak® Advantage HMO

This authorization applies to all moneys due under the agreements designated above, including payment for healthcare services and any risk-sharing settlements, if applicable.

The undersigned hereby authorizes Clinic/Group named above, or any of its duly authorized administrators, to access the undersigned's Hub Apply Portal account for the purpose of updating demographic information or credentialing elements, or to make other administrative changes.

The undersigned retains the right to revoke this authorization by giving 30 days prior written notice to Provider Network Operations, Attention Clinic/Group Billing Authorization. The undersigned understands and agrees that the Clinic/Group named above can likewise refuse to accept payment(s) authorized by this assignment. Payments for services rendered at above named Clinic/Group and due after Provider Network Operations receives the written notice of revocation of this authorization from the undersigned or refusal to accept payments from the Clinic/Group, shall be paid direct to undersigned, provided, however, that the following additional terms shall apply: (a) following execution of this Authorization, neither Arkansas Blue Cross and Blue Shield nor any other payer accessing the PPO or HMO networks (hereafter collectively referred to as "Payers") shall be obligated to redirect payment to any other location or recipient except upon 30 days' prior written notice; (b) Payers shall be entitled to require satisfactory proof of signatures and authority to redirect payment; (c) in the event of a dispute between clinic/group and the undersigned or between the undersigned and any other party regarding right to receipt of any payment, Payers may, in their sole discretion, either hold all payments until such Payers deem the dispute resolved, or Payers may make payment to clinic/group, in which case the undersigned agrees to look solely to clinic/group with respect to any claims for payment, and the undersigned hereby releases Payers from any liability with respect to such payments. By signing this form, the undersigned expressly agrees to the preceding terms and conditions of clinic/group billing.

Signature (Individual Practitioner- NO STAMPS)	Date of signature
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## Return completed form to and supporting documents:

Arkansas Blue Cross and Blue Shield  
ATTN: Provider Network Operations  
PO Box 2181  
Little Rock AR 72203-2181

or

Fax: 501-378-2465

Email: [providernetwork@arkbluecross.com](mailto:providernetwork@arkbluecross.com)