Instructions for Completing the Member Authorization Form



If you have any questions, please feel free to call us at the customer service number on your member identification card.

Please read the following for help completing page one of the form.

PART A: MEMBER INFORMATION

This section applies to the member who is asking for the release of his or her information to another person or company.

- Print your last name, first name, and middle initial
- Write your date of birth in this format: mm/dd/yyyy. (If you were born on October 5, 1960, you would write 10/05/1960.)
- Write your full street address, city, state, and ZIP code
- Write your daytime phone number (including area code)
- Identification number You will find this number on your member identification card
- Group number

You will find this number on your member identification card. If your identification card does not have a group number leave this blank.

PART B: PERSON OR COMPANY WHO WILL RECEIVE THIS INFORMATION

- Check the box that applies to you. Write the full name of the person or company that you want us to give your information to. Please don't use a general term like "my daughter" or "my son" as it will not be accepted. You need to be specific.
- If you check "Other," give the first and last name (if available), the name of the company (if applicable), and how they relate to you.

PART C: INFORMATION THAT CAN BE RELEASED

This section tells us what information you would like us to release: all or just some.

- For "all of your information," check the first box.
- For "limited information," check the second box and the boxes that apply to you.
- Some topics may be very personal or sensitive to you. If you wish to approve the release of this type of information, check the box(es) that apply to you.

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al cliente que aparece al dorso de su tarjeta						
This form is to be filled out by a member if th Please include as much information as you ca		st to release the r	nember's health	informati	on to anot	ther person or company.
PART A: MEMBER INFORMATION						
Member last name	Memi	ber first name			Middle initial	Member date of birth
Member street address	City				State	ZIP code
Daytime telephone number (with area code)	Identificatio	n number (see ide	ntification card)	Group nu	mber (see	identification card)
PART B: PERSON OR COMPANY WHO WILL						
The following people or companies have the each box that applies and enter first and la						
My spouse (enter first and last name)			My parents (if you are over 18 - enter first and last name(s)			
My domestic partner (enter first and last	name)	□ My and	My insurance broker or agent (enter the name of the company and first and last name, if you have it)			
☐ My adult children (enter first and last name[s])		□Oti	Other (enter first and last name [if you have it], name of company, and how it's related to you)			
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PART C: INFORMATION THAT CAN BE RELE		and		(8		
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Please read the following for help completing page two of the form.

PART D: PURPOSE OF THIS APPROVAL

This section tells us the reason you've asked for the release of your information.

- Check the first box to let us know to give out this information as shown on this form.
- Check the second box for a specific reason. An example might be to settle a life insurance claim.

PART E: DATE YOUR APPROVAL EXPIRES

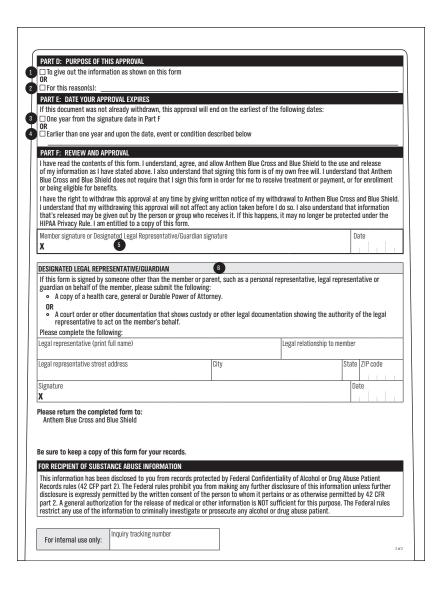
You have two choices of when you would like this approval to end.

- Check the first box for the standard one-year that it will end.
- Check the second box for an earlier date (other than one year), and give the date you wish this approval to end.

Your authorization/approval can't be granted for more than one year.

PART F: REVIEW AND APPROVAL

- Sign your name and put the date on the form. Your name and signature must match the information in Part A.
- If you are signing this form on behalf of another person, or if you have Power of Attorney for health care, or are a legal guardian/conservator you must do the following:
 - You must complete the Designated Legal Representative/Guardian section.
 - You must also provide us with a copy of the legal document showing that you are approved and include it with this form.



Examples of legal documents:

- Health Care, General or Durable Power of Attorney. This document gives someone you trust the legal power to act on your behalf and make health care decisions for you.
- Legal Guardianship. This is when the court appoints someone to care for another person.
- **Conservatorship**. This happens when a judge appoints a responsible person to make decisions for someone who can't make responsible decisions for him/herself.
- Executor of estate. This type of document would be used when the person who is being represented has died.

Member Authorization Form



Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This form is to be filled out by a member if there is a request to release the member's health information to another person or company. Please include as much information as you can. PART A: MEMBER INFORMATION Member last name Member first name Middle Member date of birth initial ZIP code Member street address City State Daytime telephone number (with area code) Identification number (see identification card) Group number (see identification card) PART B: PERSON OR COMPANY WHO WILL RECEIVE THIS INFORMATION The following people or companies have the right to receive my information. (They must be 18 years of age or older). Please check each box that applies and enter first and last name. ☐ Mv spouse (enter first and last name) ■ **My parents** (if you are over 18 - enter first and last name[s]) ☐ My domestic partner (enter first and last name) ☐ **My insurance broker or agent** (enter the name of the company and first and last name, if you have it) ☐ My adult children (enter first and last name[s]) □ **Other** (enter first and last name [if you have it], name of company, and how it's related to you) PART C: INFORMATION THAT CAN BE RELEASED I allow the following information to be used or released by Anthem Blue Cross and Blue Shield on my behalf (check only one box): ☐ **All my information**. This can include health, a diagnosis (name of illness or condition), claims, doctors and other health care providers and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below. □ **Only limited information** may be released (check all boxes below that apply to you). ☐ Eligibility and enrollment \square Appeal □ Referral ☐ Benefits and coverage ☐ Financial ☐ Treatment ☐ Billing ☐ Medical records \square Dental \square Claims and payment \square Doctor and hospital \square Vision ☐ Diagnosis (name of illness ☐ Pre-certification and pre-authorization □ Pharmacy or condition) and procedure (for treatment approvals) \square Other: (treatment) I also approve the release of the following types of sensitive information by Anthem Blue Cross and Blue Shield (check all boxes that apply to you): ☐ All sensitive information ☐ Just information about topics checked below ☐ Genetic testing \square Abortion ☐ Mental health ☐ Abuse (sexual/physical/mental) ☐ HIV or AIDS ☐ Sexually transmitted illness ☐ Alcohol/substance abuse ** ☐ Maternity \square Other:

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Indiana: Anthem Insurance Companies, Inc.
In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMD products underwritten by HMO Coloracio, Inc., doa HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire; Inc. In Ohlo: Community Insurance Company, In Virginia: Anthem Health Plans of Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), which underwrites or administers the PPO and indemnity policies; Composer Health Services Insurance Corporation (Composer), which underwrites or administers the HMO policies; and Composer and BCBSWI collectively, which underwrite to radministers the PPO spicies. Independent licensees of the Blue Cross and Blue Shield Association.

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^{**} I understand that my alcohol/substance abuse records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time, or as described below in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

PART D: PURPOSE OF THIS APPROVAL						
☐ To give out the information as shown on this form						
OR ☐ For this reason(s):						
PART E: DATE YOUR APPROVAL EXPIRES						
	end on the earliest of the	following dates:				
If this document was not already withdrawn, this approval will end on the earliest of the following dates: □ One year from the signature date in Part F						
OR "						
Earlier than one year and upon the date, event or condition d	escribed below					
PART F: REVIEW AND APPROVAL						
I have read the contents of this form. I understand, agree, and a						
of my information as I have stated above. I also understand that signing this form is of my own free will. I understand that Anthem Blue Cross and Blue Shield does not require that I sign this form in order for me to receive treatment or payment, or for enrollment						
or being eligible for benefits.	1 in order for me to receive	e treatment or payment, (or for enrollment			
I have the right to withdraw this approval at any time by giving	written notice of my withd	Irawal to Anthem Blue Cro	ss and Blue Shield.			
I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the						
HIPAA Privacy Rule. I am entitled to a copy of this form.	ceives it. ii tilis liappelis,	it iliay ilo loliger ne prote	cteu unuer the			
Member signature or Designated Legal Representative/Guardian sig	mature		Date			
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DESIGNATED LEGAL REPRESENTATIVE/GUARDIAN						
If this form is signed by someone other than the member or par guardian on behalf of the member, please submit the following:	•	presentative, legal repres	sentative or			
 A copy of a health care, general or Durable Power of Attor 	ney.					
OR	or other legal decuments	ation chowing the authori	ty of the local			
 A court order or other documentation that shows custody representative to act on the member's behalf. 	or other legal documents	ition showing the authorn	ty of the legal			
Please complete the following:						
Legal representative (print full name)		Legal relationship to mem	oer			
Legal representative street address	City		ate ZIP code			
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Signature			Date			
X						
Please return the completed form to: Anthem Blue Cross and Blue Shield						
Antiloni blue oross and blue officia						

Be sure to keep a copy of this form for your records.

FOR RECIPIENT OF SUBSTANCE ABUSE INFORMATION

This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFP part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

For internal use only:	Inquiry tracking number