

Member's Authorization Request Form

Commercial Operations / IDC

You may give Blue Cross and Blue Shield of North Carolina (Blue Cross NC) written authorization to disclose your protected health information (PHI) to anyone that you designate and for any purpose. If you wish to authorize a person or entity to receive your PHI, please complete the information below.

Parents/Guardians: We want to be able to speak with you on behalf of your dependent child (over the age of 18 or between the ages of 14-18 for certain diagnosis) about their PHI. In order to do this, we are required to have their consent by completion of this form.

MEMBER WHOSE INFORMATION W	VILL BE DISCLOSED:						
Member First Name:	M.I	Member Last Name: _					
MEMBER'S DATE OF BIRTH MONTH DAY MEMBER'S DATE OF BIRTH YES	iar	SU	BSCRIBER ID NUMBE	R (FROM YOUR ID CA	RD)		
The purpose of this disclosure is:							
to assist me with my health plan to coordinate and manage my health care Other							
At my request, I authorize Blue Cross N However, you must fill out one form per		alth Information t	o (If you choose, y	you may designa	te more than one p	erson.	
FIRST NAME	M.I.	LAST NAME					
RELATIONSHIP TO MEMBER:							
Please provide the following information to t (i) your subscriber ID number, (ii) your date of		•	rify the person's ide	entity and authority	to receive your PHI:		
I authorize Blue Cross NC to disclose t	he following PHI to the pers	son/entity listed	above. CHECK ON	NLY BOXES THAT	APPLY:		
ALL Information Requested Pre	mium Payment Information						
Enrollment Information Explanation of Benefits (EOB) Information							
Benefit Information All (Claims Information						
All Services from a Specific Health Care Provider(s) (List Provider's Name):							
Other (Please List Specific PHI and/or Date Ranges):							
If applicable, this information may contain sens behavioral health (except psychotherapy notes	_		ually transmitted or c	ommunicable diseas	ses, HIV/AIDS, mental	and	
If applicable, I authorize Blue Cross NO	C to release alcohol/substa	nce abuse inforn	nation related to	the above reques	st. Yes N	lo	

authorization into its business system, typically five (5) days following receip	t.						
If you want this authorization to become effective							
on a later date, please insert the date here:	→						
	MONTH DAY YEAR						
I would like this authorization to expire on (enter date):							
•	MONTH DAY YEAR						
OR							
WHEN MY COVERAGE EXPIRES							
(If no expiration date is provided, this authorization will expire twelve (12) months from the date of receipt.)							
I understand that I may revoke this authorization at any time by giving Blue Cross also understand that the revocation will not affect any action Blue Cross NC took NC received my written notice of revocation.							
l also understand that this authorization will not affect the provision of or payment	t for my health plan benefits.						
I also understand that if the persons or entities I authorize to receive my PHI are n Accountability Act ("HIPAA") or other federal health information privacy laws, the protected by HIPAA.							
However, if this information is protected by the Federal Substance Abuse Confide	ntiality Regulations, the recipient may not						
re-disclose such information without my further written authorization unless othe							
	TODAY'S DATE						
Signature:							
	MONTH DAY YEAR						
If signed by an Individual Other than the Member (Print your Full Name):							
Describe your authority to act for the member							
(e.g., power of attorney, court order, parent of minor child, etc.):	_						
NOTE: Please attach the legal document naming you as the personal representative if you have not previously submitted it to us.							
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Note: This authorization will become effective on the date Blue Cross NC enters this

Return this authorization to: Commercial Operations / IDC

Blue Cross and Blue Shield of North Carolina

PO Box 2291

Durham, NC 27702-2291



Non-Discrimination and Accessibility Notice

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified interpreters and/or written information in other formats (large print, accessible electronic formats, etc.)
- Free language services to people whose primary language is not English, such as: qualified interpreters and/or information written in other languages

If you need these services, call the Customer Service or TTY number on the back of your member ID card.

If you believe that Blue Cross NC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Blue Cross NC, P.O. Box 2291, Durham, NC 27702

Attention: Civil Rights Coordinator-Privacy,

Ethics & Corporate Policy Office

Call: 919-765-1663, 1-888-291-1783 (TTY)

Fax: 919-287-5613

E-mail: civilrightscoordinator@bcbsnc.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Coordinator-Privacy, Ethics & Corporate Policy Office is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:

Online: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf Mail: U.S. Department of Health & Human Services

200 Independence Avenue, SW Room 509F

HHH Building Washington, D.C., 20201 Call: 1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available online at:

http://www.hhs.gov/civil-rights/filing-a-complaint/index.html

This notice and/or attachments may have important information about your application or coverage through Blue Cross NC. Look for key dates. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. If you need these services, call the Customer Service or TTY number on the back of your member ID card.

Discrimination is Against the Law

Blue Cross NC complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Blue Cross NC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

BLUE CROSS®, BLUE SHIELD®, the Cross and Shield Symbols and service marks are marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. Blue Cross NC is an independent licensee of the Blue Cross and Blue Shield Association.



Multi-language Interpreter Services

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call the Customer Service or TTY number on the back of your member ID card.

ATENCIÓN: Si habla otro idioma, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Servicio de Atención al Cliente al número de teléfono para personas con problemas auditivos (TTY) que figura al dorso de su tarjeta de identificación.

注意:他の言語を話す方は、言語支援サービスを無料でご利用いただけます。

顧客サービスにお電話いただくか、会員IDカードの裏面にあるTTYサービスをご利用ください。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Dịch vụ khách hàng hoặc TTY trên mặt sau thẻ ID thành viên của bạn.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 가입자 ID 카드 뒷면에 있는 고객 서비스 혹은 TTY 번호로 전화해 주십시오.

ATTENTION_o: si vous parlez une autre langue, des services d'aide linguistique vous sont proposés gratuitement. Contactez le service clients au numéro figurant au dos de votre carte de membre.

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم خدمة العملاء أو رقم الهاتف النصي الموضح على ظهر بطاقة هوية العضو.

LUS CEEB TOOM: Yog tias koj hais lus Hmoob, , peb muaj kev pab txhais lus pub dawb rau koj. Hu rau Customer Service tus xov tooj los yog tus xov tooj TTY rau cov neeg tsis hnov lus zoo uas nyob sab tom qab koj daim npav ID.

ВНИМАНИЕ: Если вы говорите на другом языке, то вам доступны бесплатные услуги перевода. Позвоните в Отдел обслуживания по номеру, указанному на обратной стороне вашей идентификационной карточки участника.

PAUNAWA: Kung nagsasalita ka ng ibang lengguwahe, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tawagan ang numero ng Customer Service o TTY sa likod ng iyong member ID card.

સૂચનાઃ જો તમે ગુજરાતી બોલતા હોવ તો તમારા માટે ભાષા સેવાઓ નિઃશુ ક ઉપલ ધ છે. તમારા સ ચપદ ઓળખપ રની (આઈ.ડી) પાછળની બાજુ પર આપેલ ગરાહક સેવાઓના નંબર અથવા TTT નંબર પર કૉલ કરો.

ចំណំ៖ ប្រសិនប្របោកអ្នកនិយាយជាភាសាខ្មែរ បសវាកមជំនួយម្ភភាសាមាន្តល់ជូនសបមាប្រាកអ្នកបោយមិនគិតថ្លៃ។សូមបៅបៅកា ន់បស វាអត្ថិជនបោយបប្របល់ទូរស័ព្ទបៅខាង្នងកាត់សមាជិកស្រប់បោកអ្នក។

ACHTUNG: Falls Sie eine andere Sprache sprechen, stehen Ihnen kostenlose Sprachdienste zur Verfügung. Rufen Sie die Nummer des Kundenservices oder von TTY an, die auf der Rückseite Ihrer Mitgliedskarte angegeben ist.

ध्यान दें: यदि आप दूसरी भाषा बोलते हैं, तो आपके लिए भाषा सहायता सेवाएं, मुफ्त में, उपलब्ध हैं। अपने सदस्य आईडी कार्ड के पीछे मौजूद ग्राहक सेवा या TTY नंबर पर कॉल करें।

ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາອື່ນ, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ໄດ້ເສຍຄ່າ. ໂຫຫາຝາຍບໍລິການລູກຄ້າຫລື ເບີ TTY ຢູ່ດ້ານຫຼັງບັດປະຈຳຕົວຂອງທ່ານ.

注意:如果您講廣東話或普通話,您可以免費獲得語言援助服務。請撥打您會員 ID 卡背面的客服或TTY號的電話號碼。

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