

## **Member Authorization Request Form**

You may give Blue Cross 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 want to authorize a person or entity to receive your PHI upon their request, please provide the information below. Completion of this form is not a condition or requirement of coverage and will not change the way that Blue Cross NC communicates with you. For example, we will continue to send Explanation of Benefits (EOB) statements to you upon request. However, if your adult child calls Blue Cross NC to inquire about you, your Protected Health Information will not be shared with your adult child unless you have given Blue Cross NC permission to do so by completion of this form.

**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.

### **Please Print:**

Member's Name:			
Member's Date of Birth: MONTH DAY YEAR	Blue Cross NC ID Number:		
At my request, I authorize Blue Cross NC to disclose my Protected Health Information (PHI) to: (If you choose, you may designate more than one person. However, you must fill out one form per person.)			
Name/Entity: Add	'ess:		
	tionship ember:		
The purpose of this disclosure is:			
To assist me with my health plan To coordinate and manage my health Other:			
We request that you provide the following information to the person you have authorized so that we may verify the person's identity and authority to receive your PHI: a) your ID number, b) your date of birth, and c) your address.			
I authorize Blue Cross NC to disclose only the following Protected Health Information to the person/entity designated above. (Check all that apply.)			
Any information requested Explanation of Benefits	information		
All claims information			
	ider's name):		
Benefit information			
	fic PHI):		
If applicable, this information may contain sensitive data, including data related to treatment of sexually transmitted or communicable diseases, HIV/AIDS, mental and behavioral health (except psychotherapy notes), genetic testing and termination of pregnancy.			
If applicable, I authorize Blue Cross NC to release alcohol/substance abuse information related to the above request. Yes No			
I want the designated person/entity to have access to my PHI until my policy expires OR until the specified date of:			

(B), SM Marks of the Blue Cross and Blue Shield Association. Blue Cross and Blue Shield of North Carolina is an independent licensee of the Blue Cross and Blue Shield Association.

I understand that I may revoke this authorization at any time by giving Blue Cross NC written notice mailed to the address provided. However, if I revoke this authorization, I also understand that the revocation will not affect any action Blue Cross NC took while this authorization was valid before Blue Cross NC received my written notice of revocation.

I also understand that I do not have to authorize anyone to receive my PHI as a condition or requirement for coverage by Blue Cross NC.

I also understand that if the persons or entities I have authorized to receive my PHI are not health plans, covered health care providers, or health care clearing houses subject to the Health Insurance Portability and Accountability Act (HIPAA), or other federal health information privacy laws, they may further disclose my PHI and it may no longer be protected by HIPAA or federal health information privacy laws.

However, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

		Date
0:-		
Sig	nature of Member:	MONTH DAY YEAR
OF	R	
		Date
Sig	nature of Personal Representative:	MONTH DAY YEAR
If signed by a Personal Representative, please:		
a)	Print your full name:	
,		
	AND	
b)	b) Describe your authority to act for the member:	
	AND	actorney, court order, parent of minor child, etc.,
c)	c) Attach the legal document naming you as the personal representative when you return this form.	
No	<b>te:</b> We will consider the effective date of this authorization to be the date we	
enter this authorization into our computer system, typically 5 days following receipt.		
If you would like this authorization to become effective on a date after Blue Cross NC enters the authorization into its system, please provide the date here:		
		MONTH DAY YEAR
	ΔΕΤΙΙΔΝΙ ΤΙΙΟ ΛΙΙΤΠΟΟΙΖΑΤΙΟΝΙ	το.
RETURN THIS AUTHORIZATION TO: Attention: Data Operations		
Blue Cross and Blue Shield of North Carolina		
PO Box 2291		
	Durham, NC 27702	
Blue Cross and Blue Shield of North Carolina is an HMO, PPO and PDP plan with a Medicare contract. Enrollment in Blue		

Cross and Blue Shield of North Carolina depends on contract renewal.



### 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.

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#### 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<sup>®</sup>, BLUE SHIELD<sup>®</sup>, 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<sub>o</sub>: 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.

સૂચના: જો તમે ગુજરાતી બોલતા હોવ તો તમારા માટે ભાષા સેવાઓ નિ:શુ 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 បសវាកមជំនួយម្ភភាសាមាន្ឌល់ជូនសបមាប្រាកអ្នកបោយមិនគិតថ្លៃ។សូមបៅបៅកា ន់បស វាអតិ្ថជនបោយបប្របលទូរស័ព្ទបៅខាង្នងកាតសមាជិការ្រស់បោកអ្នក។

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: ຖ້າທ່ານເວົ້າພາສ<sup>ົ</sup>່ອື່ນ, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍໄດ້ເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການລູກຄ້າຫລື 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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