BlueCross BlueShield of North Carolina

An independent licensee of the Blue Cross and Blue Shield Association.

Member's Authorization Request Form

Commercial Operations / IDC

You may give Blue Cross and Blue Shield of North Carolina (BCBSNC) 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. **Completion of this form will not change the way that BCBSNC communicates with members or subscribers.**

MEMBER WHOSE INFORMATION WILL BE DISCLOSED:

MEMBER'S FIRST NAME M.I. MEMBER'S LAST NAME

MONTH DAY YEAR

MEMBER'S DATE OF BIRTH

SUBSCRIBER ID NUMBER *(FROM YOUR ID CARD)*

At my request, I authorize BCBSNC to disclose Protected Health Information to (enter name of person/entity who will receive member's PHI):

FIRST NAME M.I. LAST NAME

RELATIONSHIP TO MEMBER:

Please 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: (i) your subscriber ID number, (ii) your date of birth, and (iii) subscriber address.

I authorize BCBSNC to disclose the following PHI to the person/entity listed above. CHECK ONLY BOXES THAT APPLY:

☐ ALL Information Requested ☐ Enrollment Information ☐ Benefit Information ☐ Premium Payment Information ☐ Explanation of Benefits (EOB) 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 you want to authorize someone to have access to your mental health or substance abuse PHI, please call the mental health/substance abuse company's telephone number on the back of your membership card to request a separate authorization form from them.

Note: This authorization will become effective on the date BCBSNC enters this authorization into its business system, typically five (5) days following receipt. 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 BCBSNC written notice mailed to the address below. I also understand that the revocation will not affect any action BCBSNC took in reliance on this authorization before BCBSNC received my written notice of revocation.

I also understand that this authorization will not affect the provision of or payment for my health plan benefits.

I also understand that if the persons or entities I authorize to receive my PHI are not subject to the Health Insurance Portability and Accountability Act ("HIPAA") or other federal health information privacy laws, they may re-disclose the PHI and it may no longer be protected by HIPAA.

Signature: _____ **Today's Date:** 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.

Return this authorization to:

Commercial Operations / IDC
Blue Cross and Blue Shield of North Carolina
PO Box 2291, Durham, NC 27702-2291

Print Form