BlueCross BlueShield of North Carolina

BlueCrossNC.com

PO Box 30055, Durham, NC 27702-3055

Member Appeal Representation Authorization Form

I authorize Blue Cross and Blue Shield of North Carolina (Blue Cross NC) to release any of my protected health information (PHI), including information that may be related to substance use disorders, to my representative named below for the purpose of resolving my appeal. I understand that this information may contain sensitive data, including data related to reproductive health care, treatment of sexually transmitted or communicable diseases, HIV/AIDS, mental and behavioral health (except psychotherapy notes) and genetic testing. I further understand that the person(s) that I have given permission to receive my PHI may not be subject to federal health information privacy laws and that they may disclose my information and it may no longer be protected by federal health information privacy laws.

I understand that I may revoke this authorization at any time by mailing a written notice to Blue Cross NC. I understand that revoking this authorization will not affect any action that Blue Cross NC has taken prior to receiving my notice of revocation.

I further understand that Blue Cross NC will not condition the provision of my health plan benefits because of this authorization. This authorization will expire upon resolution of this appeal.

Please Note: By completing and submitting this form, you are granting authority to a third party (such as a provider or other representative) to file an appeal on your behalf. You are aware that you or your authorized representative may submit additional information to be included with the appeal or external review. **This form is not intended to be your actual appeal request.** Please ensure that your appeal request is submitted by your third-party representative it has not already been submitted to us.

Attention: *This authorization will not be accepted, if:*

- *It is dated prior to the date of the disputed adverse benefit determination.*
- *If your signature is not on this document and you are the patient, 18 years of age or older.*

All fields are required including Member Signature and Date

Patient Name:	**Person/Entity Authorized to Act on Your Behalf:**
Member ID Number:	**Representative Phone Number:**
Patient Date of Birth:	**Provider Name:**
Claim Number(s) or Service Description:	**Date(s) of Service:**

Member Signature (If member is a minor, parent's signature)

Date