PO Box 30055, Durham, NC 27702-3055

Date

Name
Address
City, State, Zip Code

Patient Name:
Member ID:
Date of Birth:
Date(s) of Service:
Provider:
Regarding:

I have given my permission for (**please enter representative's name**) to represent me, and act on my behalf regarding the above referenced denial of service(s).

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 above for the purpose of resolving my appeal.

I understand that I may revoke this authorization at any time by mailing a written notice to Blue Cross NC at the address above. I understand that revoking this authorization will not affect my 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.

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.

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. This form is not intended to be your actual appeal request. Please ensure that your appeal request is submitted by your third-party representative if it has not already been submitted to us.

Thank you,

_____ _____

Member Signature Date