

Instructions for Completing the Member Authorization Form



If you have any questions, please feel free to call us at the Member Services number on your member identification card.

Please read the following for help completing page one of the form.

PART A: MEMBER INFORMATION

This section applies to the member who is asking for the release of his or her information to another person or company.

- 1 Print your last name, first name and middle initial.
- 2 Write your date of birth in this format: mm/dd/yyyy. (If you were born on October 5, 1960, you would write 10/05/1960.)
- 3 Write your full street address, city, state and ZIP code.
- 4 Write your daytime phone number (including area code).
- 5 **Identification number:** You will find this number on your member identification card.
- 6 **Group number:** You will find this number on your member identification card. If your identification card does not have a group number, leave this blank.

PART B: PERSON OR COMPANY WHO WILL RECEIVE THIS INFORMATION

- 7 Check the box that applies to you. Write the full name of the person or company that you want us to give your information to. Please don't use a general term like "my daughter" or "my son," as it will not be accepted. You need to be specific.
- 8 If you check "Other," give the first and last name (if available), the name of the company (if applicable) and how they relate to you.

PART C: INFORMATION THAT CAN BE RELEASED

This section tells us what information you would like us to release: all or just some.

- 9 For "all of your information," check the first box.
- 10 For "limited information," check the second box and the box(es) that apply to you.
- 11 Some topics may be very personal or sensitive to you. If you wish to approve the release of this type of information, check the box(es) that apply to you.

Member Authorization Form

SecureBlueSM (HMO SNP) is a health plan that contracts with both Medicare and the Minnesota Medical Assistance (Medicaid) program to provide benefits of both programs to enrollees. Enrollment in SecureBlue depends on contract renewal.

This form is to be filled out by a member if there is a request to release the member's health information to another person or company. Please include as much information as you can.

Part A: Member information

Member last name	Member first name	Middle initial	Member date of birth
Member street address	City	State	ZIP code
Daytime telephone number (with area code)	Identification number (see identification card)	Group number (see identification card)	

Part B: Person or company who will receive this information

The following people or companies have the right to receive my information. (They must be 18 years of age or older.) Please check each box that applies and enter first and last name.

<input type="checkbox"/> My spouse (enter first and last name)	<input type="checkbox"/> My parents (if you are over 18 – enter first and last name(s))
<input type="checkbox"/> My domestic partner (enter first and last name)	<input type="checkbox"/> My insurance broker or agent (enter the name of the company and first and last name, if you have it)
<input type="checkbox"/> My adult children (enter first and last name(s))	<input type="checkbox"/> Other (enter first and last name (if you have it), name of company, and their relation to you)

Part C: Information that can be released

Allow the following information to be used or released by Blue Plus on my behalf (check only one box):

All my information. This can include health, a diagnosis (name of illness or condition), claims, doctors and other health care providers, and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below.

Only limited information may be released (check all boxes below that apply to you).

<input type="checkbox"/> Appeal	<input type="checkbox"/> Eligibility and enrollment	<input type="checkbox"/> Referral
<input type="checkbox"/> Benefits and coverage	<input type="checkbox"/> Financial	<input type="checkbox"/> Treatment
<input type="checkbox"/> Billing	<input type="checkbox"/> Medical records	<input type="checkbox"/> Dental
<input type="checkbox"/> Claims and payment	<input type="checkbox"/> Doctor and hospital	<input type="checkbox"/> Vision
<input type="checkbox"/> Diagnosis (name of illness or condition) and procedure (treatment)	<input type="checkbox"/> Pre-certification and pre-authorization (for treatment approvals)	<input type="checkbox"/> Pharmacy
		<input type="checkbox"/> Other: _____

I also approve the release of the following types of sensitive information by Blue Plus (check all boxes that apply to you):

All sensitive information

Just information about topics checked below

<input type="checkbox"/> Abortion	<input type="checkbox"/> Genetic testing	<input type="checkbox"/> Mental health
<input type="checkbox"/> Abuse (sexual/physical/mental)	<input type="checkbox"/> HIV or AIDS	<input type="checkbox"/> Sexually transmitted illness
<input type="checkbox"/> Substance use disorder*	<input type="checkbox"/> Maternity	<input type="checkbox"/> Other: _____

*Specify time period of records to be disclosed: _____ and description of records that may be disclosed: _____

SecureBlue 1-888-740-6013; TTY 711, this call is free

Attention. If you need free help interpreting this document, call the above number.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Digniin. Haaddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

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SecureBlueSM (HMO SNP) is a health plan that contracts with both Medicare and the Minnesota Medical Assistance (Medicaid) program to provide benefits of both programs to enrollees. Enrollment in SecureBlue depends on contract renewal.

Please read the following for help completing page two of the form.

PART D: PURPOSE OF THIS APPROVAL

This section tells us the reason you've asked for the release of your information.

- 1 Check the first box to let us know to give out this information as shown on this form.
- 2 Check the second box for a specific reason. An example might be to settle a life insurance claim.

PART E: DATE YOUR APPROVAL EXPIRES

You have two choices of when you would like this approval to end.

- 3 Check the first box for the standard one-year time that it will end.
- 4 Check the second box for an earlier date (other than one year), and give the date you wish this approval to end.

Your authorization/approval can't be granted for more than one year.

PART F: REVIEW AND APPROVAL

- 5 Sign your name and put the date on the form. Your name and signature *must* match the information in Part A.
- 6 If you are signing this form on behalf of another person, or if you have Power of Attorney for health care, or are a legal guardian/conservator you must do the following:
 - o You must complete the Designated Legal Representative/Guardian section.
 - o You must also provide us with a copy of the legal document showing that you are approved and include it with this form.

*Unless I specify otherwise on this form, I intend this disclosure to include all substance use disorder records maintained by Anthem about me. I understand that my substance use disorder records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time, or as described in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

Part D: Purpose of this approval

1 To give out the information as shown on this form
 OR
 2 For this reason(s): _____

Part E: Date your approval expires

If this document was not already withdrawn, this approval will end on the earliest of the following dates:

3 One year from the signature date in Part F
 OR
 4 Earlier than one year and upon the date, event or condition described below: _____

Part F: Review and approval

I have read the contents of this form. I understand, agree, and allow Blue Plus to the use and release of my information as I have stated above. I also understand that signing this form is of my own free will. I understand that Blue Plus does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to Blue Plus. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Member signature or Designated Legal Representative/Guardian signature	Date
X	_____

DESIGNATED LEGAL REPRESENTATIVE/GUARDIAN

If this form is signed by someone other than the member or parent, such as a personal representative, legal representative or guardian on behalf of the member, please submit the following:

- o A copy of a health care, general or Durable Power of Attorney.

OR

- o A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.

Please complete the following:

Legal representative (print full name)	Legal relationship to member
_____	_____
Legal representative street address	City
_____	_____
State/ZIP code	_____
Signature	Date
X	_____

Please return the completed form to:
 Blue Plus
 P.O. Box 62509
 Virginia Beach, VA 23466-9761

Be sure to keep a copy of this form for your records.

FOR RECIPIENT OF SUBSTANCE ABUSE INFORMATION

This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

For internal use only:	Inquiry tracking number

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Examples of legal documents:

- o **Health Care, General or Durable Power of Attorney.** This document gives someone you trust the legal power to act on your behalf and make health care decisions for you.
- o **Legal Guardianship.** This is when the court appoints someone to care for another person.
- o **Conservatorship.** This happens when a judge appoints a responsible person to make decisions for someone who can't make responsible decisions for himself/herself.
- o **Executor of estate.** This type of document would be used when the person who is being represented has died.

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Signature X			Date

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