Instructions for completing the *Member Authorization Form*



If you have any questions, please feel free to call us at the customer service 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.
- 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.
- Write your daytime phone number (including area code.)
- Write your cell/mobile number (including area code).
- Identification number You will find this number on your member identification card.
- 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

- 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.
- 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.

- For "all of your information," check the first box.
- For "limited information," check the second box and the boxes that apply to you.
- 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.

		e servicio al client	te que aparece al	le solicitarla sin costo dorso de su tarjeta de ide ise the member's health inf		
	include as much informati		a roquost to rolou	se die member e nediai in	ormation to an	outer person or company
Part A:	Member information					
Membe	er last name		Member first na	ame	Middle initial	Member date of birth (MM/DD/YYYY)
Membe	r street address		City		State	ZIP code
Daytim (with a	e telephone number rea code)	Cell/mobile tele (with area code	phone number	Identification number (see identification card)	Group (see i	number dep recation card)
Part B:	Person or company wh	o will receive th	is information			
The fo	llowing people or compar	nies have the righ	t to receive my in	nformation. (They must be n may receive my informat		e or older). Please ente
My sp	ouse (enter first and last n	ame)		My parents (if you are ov	er 18 – enter fi	rst and last name[s])
	8					
My domestic partner (enter first and last name)				My insurance broker or agent (enter the name of the company and first and last name, if you have it)		
My ad	ult children (enter first an	d last name(s))		Other (enter first and last	name [if you ha	ive it], name of company,
•	₩			and how it's related to yo	u) g	
	Information that can b					
□ A a OR	only one box. Il my information. This can Ind financial information (li Inly limited information (li	ke billing and banl	king). This doesn't	of illness or condition), clair include sensitive informati	ns, doctors and on (see below)	other health care provid unless it is approved belo
	□ Appeal	,	Doctor and ho	,	□ Referral	
	☐ Benefits and coverage	ge	☐ Eligibility and		□ Treatment	
A	☐ Billing ☐ Claims and payment		☐ Financial ☐ Medical record	le .	□ Dental □ Vision	
	Diagnosis (name of il or condition) and pro (treatment)	liness		on and pre-authorization	☐ Pharmacy ☐ Other:	
	approve the release of th Il sensitive information		of sensitive infor	mation by Anthem (check	all boxes that	apply to you):
ונם	ust information about to					
	☐ Abortion ☐ Abuse (sexual/physic ☐ Substance use disor	cal/mental)	☐ Genetic testing ☐ HIV or AIDS ☐ Maternity	g	☐ Mental hea☐ Sexually tr☐ Other:	alth ansmitted illness
Desi	cify time period of record cription of records that m	nay he disclosed:				
	ss I specify otherwise on iem about me. Lundersta	this form, I inten nd that my substa	d this disclosure t ance use disorder	to include all substance us records are protected und n consent unless otherwis approval at any time, or a sed to disclose informatio	e disorder reco ler Federal and	ords maintained by State confidentiality

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.

- Check the first box to let us know to give out this information as shown on this form.
- 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.

- Check the first box for the standard one year that it will end.
- 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

- Sign your name and put the date on the form. Your name and signature must match the information in Part A.
- 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:
 - You must complete the Designated Legal Representative/Guardian section.
 - You must also provide us with a copy of the legal document showing that you are approved and include it with this form.

OR The state of th	orm.				
☐ For this reason(s):					
Part E: Date your approval expires – Check onl					
If this document was not already withdrawn, this One year from the signature date in Part F.	approval will end	d on the earliest of the	following dates:		
OR					
☐ Earlier than one year and upon the date, event	or condition des	cribed below:			
Part F: Review and approval					
I have read the contents of this form. I understar stated above or as required by applicable law. I a Anthem does not require that I sign this form in of for benefits.	ilso understand t	hat signing this form is	of my own free will.	I underst	and that
I have the right to withdraw this approval at any withdrawing this approval will not affect any act given out by the person or group who receives it. entitled to a copy of this form.	ion taken before	I do so. I also understa	nd that information	hat's rele	eased may be
Member signature or Designated Legal Representative/Guardian signature				Date (MN	I/DD/YYYY)
Complete this section only if you have documer If this form is signed by someone other than the guardian on behalf of the member, please submit A copy of a health care, general or Durable	member or paren the following:	it, such as a personal r		epresent	ative or
Complete this section only if you have documer If this form is signed by someone other than the guardian on behalf of the member, please submit • A copy of a health care, general or Durable OR • A court order or other documentation that representative to act on the member's beh	member or paren the following: Power of Attorne shows custody o	nt, such as a personal r ey.	epresentative, legal (
Complete this section only if you have documer If this form is signed by someone other than the guardian on behalf of the member, please submit • A copy of a health care, general or Durable OR • A court order or other documentation that representative to act on the member's beh Please complete the following:	member or paren the following: Power of Attorne shows custody o	nt, such as a personal r ey.	epresentative, legal of the aution showing the au	thority o	
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Complete this section only if you have documer If this form is signed by someone other than the guardian on behalf of the member, please submit • A copy of a health care, general or Durable OR • A court order or other documentation that representative to act on the member's beh Please complete the following: Legal representative (print full name)	member or paren t the following: Power of Attorne shows custody of alf.	it, such as a personal r ey. r other legal document	epresentative, legal of the aution showing the au	member	f the legal
Complete this section only if you have documer If this form is signed by someone other than the guardian on behalf of the member, please submit • A copy of a health care, general or Durable OR • A court order or other documentation that representative to act on the member's beh Please complete the following: Legal representative (print full name) Legal representative street address Signature X	member or paren t the following: Power of Attorne shows custody of alf.	it, such as a personal r ey. r other legal document	epresentative, legal of the aution showing the au	member	f the legal
guardian on behalf of the member, please submit • A copy of a health care, general or Durable OR • A court order or other documentation that representative to act on the member's beh Please complete the following: Legal representative (print full name) Legal representative street address Signature	member or paren the following: Power of Attorne shows custody or alf.	it, such as a personal r ey. r other legal document	epresentative, legal of the aution showing the au	member	f the legal
Complete this section only if you have documer If this form is signed by someone other than the guardian on behalf of the member, please submit • A copy of a health care, general or Durable OR • A court order or other documentation that representative to act on the member's beh Please complete the following: Legal representative (print full name) Legal representative street address Signature X Please return the completed form to: Anthem Blue Cross and Blue Shield	member or paren the following: Power of Attorne shows custody or alf. Ci	it, such as a personal r ey. r other legal document	epresentative, legal of the aution showing the au	member	f the legal

Examples of legal documents:

- 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.
- Legal Guardianship. This is when the court appoints someone to care for another person.
- **Conservatorship**. This happens when a judge appoints a responsible person to make decisions for someone who can't make responsible decisions for him/herself.
- Executor of estate. This type of document would be used when the person who is being represented has died.

Member Authorization Form



Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción. 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

i di CA. Monibol information						
Member last name		Member first name			iddle itial	Member date of birth (MM/DD/YYYY)
Member street address		City		St	tate	ZIP code
Daytime telephone number (with area code) Cell/mobile teleph (with area code)		hone number Identification number (see identification card)			Group number (see identification card)	
Part B: Person or company who	will receive this	information				
The following people or companion first and last name. By entering t	to receive my inf low that person	ormation. (They must be may receive my informat	18 year: ion.	s of age	or older). Please enter	
My spouse (enter first and last nar		My parents (if you are over 18 – enter first and last name[s])			t and last name[s])	
My domestic partner (enter first a		My insurance broker or agent (enter the name of the company and first and last name, if you have it)				
My adult children (enter first and		Other (enter first and last name [if you have it], name of company, and how it's related to you)				
Part C: Information that can be released						
I allow the following information Check only one box. All my information. This can and financial information (like OR Only limited information material and coverage Benefits and coverage Billing Claims and payment Diagnosis (name of illror condition) and procedure at the condition of the condi	f illness or condition), clain nclude sensitive information low that apply to you). pital nrollment s n and pre-authorization approvals)	ns, docto on (see b Refe Trea Dent Visio Phar	ors and o delow) un erral tment tal on rmacy er:	ther health care providers less it is approved below.		
I also approve the release of the All sensitive information ² OR Just information about top Abortion Abuse (sexual/physica Substance use disorde	nation by Anthem (check	□ Men	tal healt Jally trar			
Specify time period of records Description of records that ma Unless I specify otherwise on t	his form. I intend	this disclosure to	o include all substance us	e disord	er record	ds 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.						

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky; Inc. In Maine: Anthem Health Plans of Kentucky: Inc. In Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwritten by HMO Colorado, Inc. do HMO Mesouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwritten by HMO Colorado, Inc. do HMO Mesouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwritten by HMO Mesouri, Inc. HMO products underwritten by HMO Colorado, Inc., do HMO Mesouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwritten by HMO Mesouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwritten by Matthew Mountain Hospital and Medical Service, Inc. HMO products underwritten by Matthew Thornton Health Plans of New Hampshire. Anthem Heal

Part D: Purpose of this approval — Check only one box.				
☐ To give out the information as shown on this form.				
OR □ For this reason(s):				
-				
Part E: Date your approval expires — Check only one box.				
If this document was not already withdrawn, this approval will One year from the signature date in Part F.	end on the earliest of the	following dates:		
OR				
\square Earlier than one year and upon the date, event or condition α	lescribed below:			
Part F: Review and approval				
I have read the contents of this form. I understand, agree, and stated above or as required by applicable law. I also understan Anthem does not require that I sign this form in order for me to for benefits.	d that signing this form is	of my own free will.	I underst	and that
I have the right to withdraw this approval at any time by giving withdrawing this approval will not affect any action taken before given out by the person or group who receives it. If this happen entitled to a copy of this form.	re I do so. I also understan	d that information t	that's rele	ased may be
Member signature or Designated Legal Representative/Guardian signature Date (MM/				
X				
Designated Legal Representative/Guardian — Complete this section only if you have documentation suppo	rting Legal Representatio	n.		
If this form is signed by someone other than the member or pa guardian on behalf of the member, please submit the following • A copy of a health care, general or Durable Power of Atto	:	presentative, legal ı	represent	ative or
 OR A court order or other documentation that shows custody representative to act on the member's behalf. 	•	tion showing the au	ithority o	f the legal
Please complete the following:				
Legal representative (print full name)	Legal relationship to	to member		
Legal representative street address	City		State	ZIP code
Signature	'		Date (MM	/DD/YYYY)
X				
Please return the completed form to: Anthem Blue Cross and Blue Shield				

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

For recipient of substance use disorder 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 patient with a diagnosis of substance use disorder.

For internal use only:	Inquiry tracking number
. or internal account.	