Instructions for Completing the Designation of Representative/Authorization Form

Anthem

This form is to be used for a grievance or an appeal and to allow a party to act as the Authorized Representative in carrying out a grievance or an appeal.

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 or a request to appoint an Authorized Representative. Please include as much information as you can.

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.

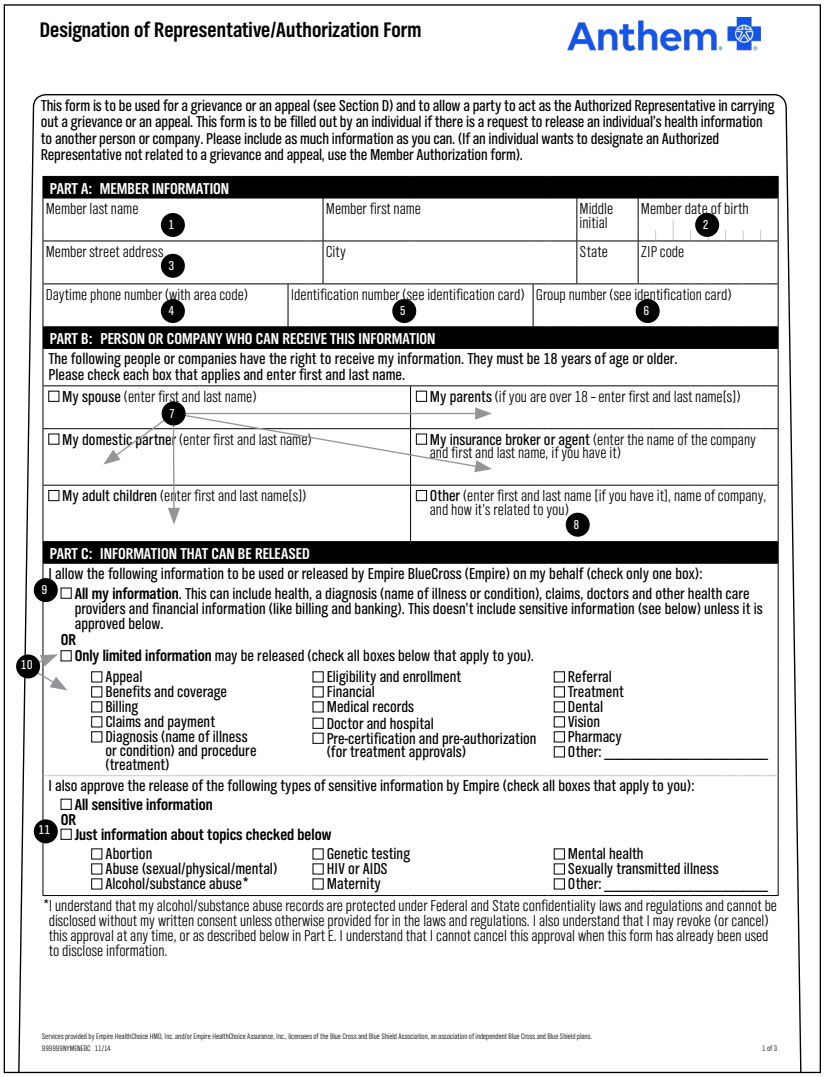
PART B: PERSON OR COMPANY WHO CAN RECEIVE THIS INFORMATION

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 (this does not include sensitive information).
10. For "limited information," check the second box and the boxes 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.



Designation of Representative/Authorization Form

Anthem

This form is to be used for a grievance or an appeal (see Section D) and to allow a party to act as the Authorized Representative in carrying out a grievance or an appeal. This form is to be filled out by an individual if there is a request to release an individual's health information to another person or company. Please include as much information as you can. (If an individual wants to designate an Authorized Representative not related to a grievance and appeal, use the Member Authorization form).

PART A: MEMBER INFORMATION

Member last name 1	Member first name	Middle initial	Member date of birth 2
Member street address 3	City	State	ZIP code
Daytime phone number (with area code) 4	Identification number (see identification card) 5	Group number (see identification card) 6	

PART B: PERSON OR COMPANY WHO CAN 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.

- ☐ **My spouse** (enter first and last name) 7
- ☐ **My parents** (if you are over 18 - enter first and last name(s))
- ☐ **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 adult children** (enter first and last name(s))
- ☐ **Other** (enter first and last name (if you have it), name of company, and how it's related to you) 8

PART C: INFORMATION THAT CAN BE RELEASED

I allow the following information to be used or released by Empire BlueCross (Empire) on my behalf (check only one box):

9 ☐ **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.

OR

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

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

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

☐ **All sensitive information**

OR

11 ☐ **Just information about topics checked below**

- ☐ Abortion
- ☐ Abuse (sexual/physical/mental)
- ☐ Alcohol/substance abuse*
- ☐ Genetic testing
- ☐ HIV or AIDS
- ☐ Maternity
- ☐ Mental health
- ☐ Sexually transmitted illness
- ☐ Other: _____

*I understand that my alcohol/substance abuse 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 below in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

Services provided by Empire HealthChoice HMO, Inc. and/or Empire HealthChoice Assurance, Inc., licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

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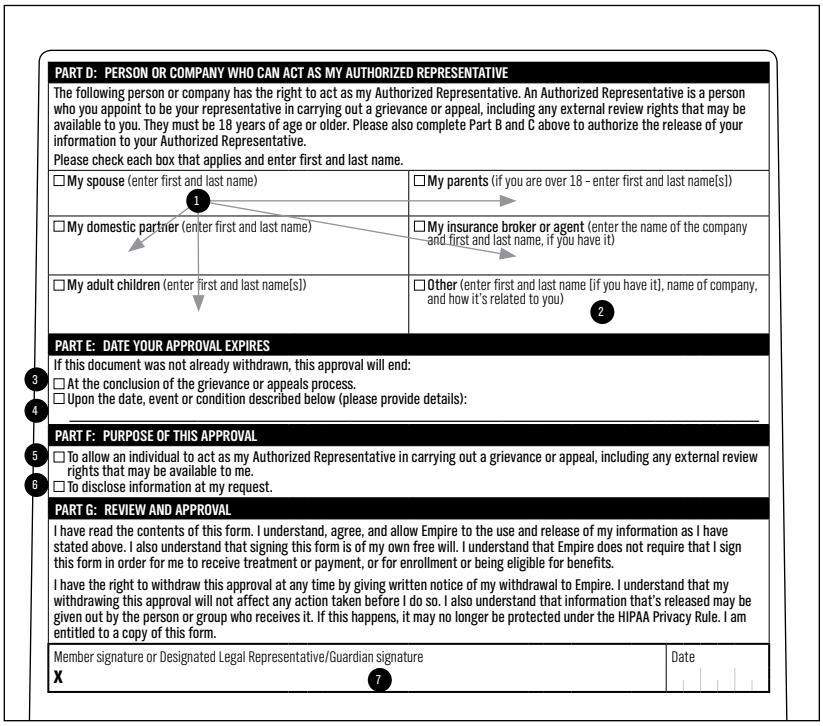
Please read the following for help completing page two and three of the form.

PART D: PERSON OR COMPANY WHO CAN ACT AS MY AUTHORIZED REPRESENTATIVE

This section tells us who you have given the right to act as your Authorized Representative in carrying out a grievance or appeal. Part B and C must also be completed to authorize the release of your information.

1. Check the box that applies to you. Write the full name of the person or company that you want to act as your Authorized Representative. Please don't use a general term like "my daughter" or "my son" as it will not be accepted. You need to be specific.
2. 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 E: DATE YOUR APPROVAL EXPIRES

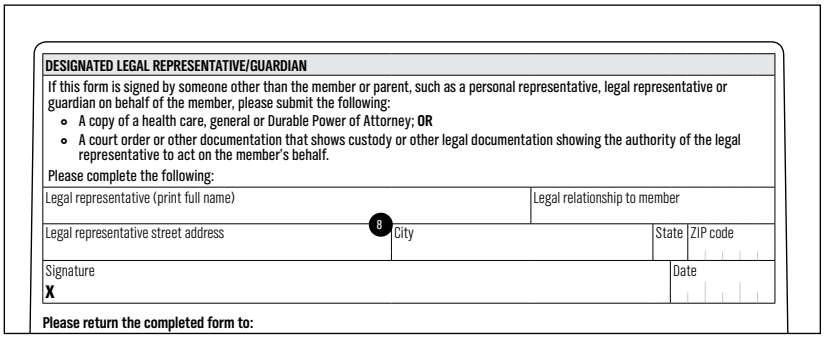
You have two choices of when you would like this approval to end.

3. Check the first box for the conclusion of the grievance or appeal process.
4. Check the second box for an earlier date (please provide details).

PART F: PURPOSE OF THIS APPROVAL

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

5. Check the first box to let us know who to give out this information as shown on this form.
6. Check the second box to let us know what information to give out (identified in Part C).



PART G: REVIEW AND APPROVAL

7. **Sign your name and put the date on the form.** Your name and signature ***must*** match the information in Part A.
8. **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.

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.

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Designation of Representative/Authorization Form

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PART A: MEMBER INFORMATION

Member last name	Member first name	Middle initial	Member date of birth

Member street address	City	State	ZIP code

Daytime phone number (with area code)	Identification number (see identification card)	Group number (see identification card)

PART B: PERSON OR COMPANY WHO CAN 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.

☐ **My spouse** (enter first and last name)	☐ **My parents** (if you are over 18 – enter first and last name[s])
☐ **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 adult children** (enter first and last name[s])	☐ **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 to be used or released by Empire BlueCross (Empire) 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.

OR

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

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

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

☐ **All sensitive information**

OR

☐ **Just information about topics checked below**

- ☐ Abortion
- ☐ Abuse (sexual/physical/mental)
- ☐ Alcohol/substance abuse*
- ☐ Genetic testing
- ☐ HIV or AIDS
- ☐ Maternity
- ☐ Mental health
- ☐ Sexually transmitted illness
- ☐ Other: _____

*I understand that my alcohol/substance abuse 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 below in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

PART D: PERSON OR COMPANY WHO CAN ACT AS MY AUTHORIZED REPRESENTATIVE

The following person or company has the right to act as my Authorized Representative. An Authorized Representative is a person who you appoint to be your representative in carrying out a grievance or appeal, including any external review rights that may be available to you. They must be 18 years of age or older. Please also complete Part B and C above to authorize the release of your information to your Authorized Representative.

Please check each box that applies and enter first and last name.

☐ **My spouse** (enter first and last name)	☐ **My parents** (if you are over 18 - enter first and last name[s])
☐ **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 adult children** (enter first and last name[s])	☐ **Other** (enter first and last name [if you have it], name of company, and how it's related to you)

PART E: DATE YOUR APPROVAL EXPIRES

If this document was not already withdrawn, this approval will end:

☐ At the conclusion of the grievance or appeals process.
☐ Upon the date, event or condition described below (please provide details):

_____

PART F: PURPOSE OF THIS APPROVAL

☐ To allow an individual to act as my Authorized Representative in carrying out a grievance or appeal, including any external review rights that may be available to me.
☐ To disclose information at my request.

PART G: REVIEW AND APPROVAL

I have read the contents of this form. I understand, agree, and allow Empire 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 Empire 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 Empire. 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:

- A copy of a health care, general or Durable Power of Attorney; **OR**
- 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 **X**		Date	

Please return the completed form to:

Anthem BlueCross

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.

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