Blue Cross Community MMAI (Medicare-Medicaid Plan)℠

Member Authorization Form

This form must be filled out by a member or member's legal representative. It allows a person or company to see or talk about the member's records. Please write in as much about yourself or the member as you can. If you need help filling out this form, you can call the number listed on your ID card.

PART A: MEMBER

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)	**Member ID number (see member ID card)**	**Group number (see member ID card)**	

PART B: PEOPLE OR COMPANIES WHO WILL GET MY RECORDS

The people or companies listed and checked below have the right to see my records or talk to Blue Cross Community MMAI about my health care. (They must be 18 or older). Please check each box that applies.

❑ My spouse (first and last name)	❑ My parents (If you are over 18, write in first and last names)
❑ My adult children (first and last names)	❑ Other (First and last name if you have it. This could be a person or the name of company. Also write what this person or company has to do with you.)

PART C: MY RECORDS

I will let Blue Cross Community MMAI℠ share or discuss the records below (check only one box):

❑ **All my health records.** This can be records about your health, a diagnosis (name of illness or health problem), claims, names of doctors and other health care providers. Checking this box won't let others see sensitive (very personal) records unless I agree to it below. **OR**

❑ **Only some records** (check all that apply to you)

- ❑ Appeal
- ❑ Benefits and coverage
- ❑ Claims and payment
- ❑ Dental
- ❑ Diagnosis (name of illness or health problem)
- ❑ Eligibility
- ❑ Pharmacy
- ❑ Prior authorization (for treatment approvals). This is when we give you an OK for a treatment.
- ❑ Referral (when your main doctor says it's OK to see a special doctor for certain treatment)
- ❑ Treatment
- ❑ Vision
- ❑ Other: _____

I also will let Blue Cross Community MMAI share this type of sensitive (very personal) records below. Check all boxes that apply to you.

❑ **All sensitive records below OR**

❑ **Just some records about topics checked below:**

- ❑ Abortion
- ❑ Abuse (sexual/physical/mental)
- ❑ Alcohol and drug abuse*
- ❑ Being pregnant
- ❑ HIV or AIDS
- ❑ Mental health
- ❑ Sexual diseases passed on to others
- ❑ Testing of genes
- ❑ Other: _____

PART D: WHY YOU WANT YOUR RECORDS SHARED

❑ Legal ❑ Insurance ❑ Personal ❑ Care Coordination

OR

❑ Special reason(s): _____

PART E: REVIEW AND SIGN

Once I sign and send in the form, it will be good for:

❑ One year from the day I signed the form

OR

❑ Other (insert date or event):

_____

I have read each part of this form. I know, agree, and will let Blue Cross Community MMAI use and give out my records as I have stated above. I also know that I signed this form of my own free will. I know that I don't need to sign this form to get treatment or payment, or for signing up for or getting benefits.

I have the right to take back what I agreed to in this form at any time. I will tell Blue Cross Community MMAI in writing that I'm doing so. I know that taking this back will not change any action taken before I do so. I also know that any records that a person or group gets (that I've agreed to) may be given out. If this happens, the records may no longer be protected under the HIPAA Privacy Rule.

Member signature (If member is a minor, parent's signature) **X**	Date | | | | | | | |

You have the right to keep a copy of this form after you finish filling it out. Please make a copy for your records. Return this completed form in the envelope we sent you with this form.

NAMED LEGAL PERSON OR GUARDIAN

If there is a person who is signing for the member (someone who takes care of the member), we need these forms filled out:
A copy of a health care, general or Durable Power of Attorney.

OR

A court order or other proof that shows that someone else has the legal right to care for a person.
Other proof can be legal forms that show someone can by law act for the member. Complete the boxes below:

Legal representative for member (print full name)		Legal representative's relationship to member	
Legal representative's street address	City	State	ZIP code | | | | | | | | |
Signature **X**			Date | | | | | | | |

Please return the completed form to: Blue Cross Community MMAI Member Services, PO Box 3418, Scranton, PA 18505
or fax to: **1-855-674-9193**

*I know that my alcohol and drug abuse records are protected under federal and state laws and rules. This form will keep these records private. No records can be given out without my saying so in writing. This is unless it says so in the laws and rules. I also know that I may take back the fact that I agreed to this at any time. Or as it is shown in Part E. I know that I cannot cancel this signed form after we have given out your health records. If I cancel the signed form, it does not apply to records given out before the form was canceled.

For internal use only:
Inquiry tracking number

Blue Cross and Blue Shield of Illinois complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross and Blue Shield of Illinois does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Illinois:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Civil Rights Coordinator.

If you believe that Blue Cross and Blue Shield of Illinois has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, Office of Civil Rights Coordinator, 300 E. Randolph St., 35th floor, Chicago, Illinois 60601, 1-855-664-7270, TTY/TDD: 1-855-661-6965, Fax: 1-855-661-6960, Civilrightscoordinator@hcsc.net. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-723-7702 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-723-7702 (TTY: 7-1-1).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-723-7702 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-723-7702（TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-723-7702 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-723-7702 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-723-7702 (رقم هاتف الصم والبكم:711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-723-7702 (телетайп: 711).

સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-877-723-7702 (TTY: 711).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-877-723-7702 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-723-7702 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-723-7702 (TTY: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-723-7702 (TTY: 711) पर कॉल करें।

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-723-7702 (ATS: 711).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-877-723-7702 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-723-7702 (TTY: 711).