North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

Date:

Name:
Address:
City, State ZIP:

Patient:
Date of Birth:
Date(s) of Service:
Provider:
Reference Inquiry:
Regarding:

I have given my permission for _____ to represent me, and act on my behalf regarding the above referenced denial for the following service(s): _____.

I authorize Blue Cross and Blue Shield of North Carolina (Blue Cross NC) to release any of my protected health information (PHI) 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 below. 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.

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This authorization will expire upon resolution of this appeal.

Thank you,

_____ _____
Member Signature Date