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

MEMBER AUTHORIZATION REQUEST FORM

The purpose of this disclosure is to: ☐ To assist me with my health plan ☐ To coordinate and manage my health

☐ Other: _____

You may give The State Health Plan for Teachers and State Employees (SHP), hereinafter referred to as "the Plan", written authorization to disclose your Protected Health Information (PHI) to anyone you designate and for any purpose. If you wish to authorize a person or entity to receive your PHI, please complete the information below. **Completion of this form will not change the way that the Plan communicates with members or dependents.** ***For example, we will still send Explanation of Benefits (EOB) statements to the member.***

Member's Name Whose Information will be Disclosed

/ /
Member Date of Birth (mm/dd/yyyy)

YPY
Blue Cross NC ID Number

Member Address

At my request, I authorize Blue Cross NC to disclose my Protected Health Information (PHI) to:
(If you choose, you may designate more than one representative. **NOTE: Both representatives will be authorized to receive the same information.**)

AUTHORIZED REPRESENTATIVE 1

Name/Entity

Address Line 1

City State Zip

Phone

Relationship to Member

AUTHORIZED REPRESENTATIVE 2

Name/Entity

Address Line 1

City

Phone

Relationship to Member

We request that you **provide the following information to the person you have authorized** so that we may verify the person's identity and authority to receive your PHI: **A)** your ID number, **B)** your date of birth, and **C)** your address.

I authorize the Plan and Blue Cross NC to disclose only the following Protected Health Information to the person(s) designated above (check all that apply)**:**

☐ Any Information requested
☐ All Claims information
☐ Enrollment information
☐ Premium payment information
☐ Benefit information
☐ Explanation of Benefits (EOB) information
☐ All services from a specific health care provider (list provider's name): _____

☐ Other (please list specific PHI): _____

If applicable, this information may contain sensitive data, including data related to treatment of sexually transmitted or communicable diseases, HIV/AIDS, mental and behavioral health (except psychotherapy notes), genetic testing and termination of pregnancy.

If applicable, I authorize Blue Cross NC to release alcohol/substance abuse information related to the above request. ☐ **Yes** ☐ **No**

I would like this authorization to expire on: ☐☐/☐☐/☐☐☐☐ (MONTH / DAY / YEAR) **OR** ☐ **When my coverage expires.**

(If no expiration date is provided, this authorization will expire twelve (12) months from the date of receipt. If for Minor child, at age 18.)

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- I understand that I may revoke this authorization at any time by giving the Plan written notice mailed to the address at the bottom of this form. I also understand that revocation will not affect any action the Plan and their business associates took in reliance upon this authorization before receiving my written notice of revocation.
- I also understand that the Plan will not condition the provision of health plan benefits on this authorization.
- I further understand that if the persons or entities I authorize to receive my PHI are not health plans, covered health care providers or health care clearinghouses subject to the Health Insurance Portability and Accountability Act (HIPAA) or other federal health information privacy laws, they may further disclose my PHI and it may no longer be protected by HIPAA or federal health information privacy laws.
- I also release and discharge the Plan and their business associates, including Blue Cross and Blue Shield of North Carolina, from any and all liability, cost and claims of whatsoever kind and nature arising from the release of this information.
- However, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

Signature:_____ ☐☐/☐☐/☐☐☐☐
MONTH DAY YEAR

Print Name as Personal Representative: _____

☐ **Power of Attorney / Administrator / Estate Executor** ☐ **Parent of Minor Child** ☐ **Legally Appointed Guardian**

If your authority to act for the Member is any of the following, please submit proper documentation along with this form: A) Power of Attorney B) Parent of Minor Child, C) Legally Appointed Guardian, or D) Executor / Administrator of Estate.

A Health Care Power of Attorney without Language authorizing the disclosure of PHI is NOT acceptable documentation.

NOTE: The Plan will consider the effective date of this authorization to be the date Blue Cross NC enters this authorization into its system, typically five days following receipt. If you would like this authorization to become effective on a later date, please indicate: ☐☐/☐☐/☐☐☐☐
MONTH DAY YEAR

RETURN THIS AUTHORIZATION BY MAIL OR FAX: 919-287-8764

MAIL: Attn: AUTHORIZATION DEPARTMENT
STATE HEALTH PLAN
PO BOX 30111 • DURHAM, NC 27702-3111

***Questions?* Call: 888-234-2416**

Instructions For Filling Out The Authorization Request Form

+ **Submitting this Authorization Form is OPTIONAL.** You do not need to send it unless you want someone else to have access to your Protected Health Information (PHI) such as your spouse, a family member or friend. This is your choice. Also, you do not need to submit an authorization form in order for the Plan to pay your claims. Submitting this authorization form will not affect your coverage.
+ **Up to TWO (2) Representatives per form.** Only one person may give their authorization per form. You may include up to 2 representatives per form.
+ **You MUST fill in the following information on the form;** otherwise, the Plan cannot accept your authorization request.

1. **Member's Name whose information will be disclosed** = your name if it is your policy. If you are completing this as a representative for another person, that person's name.
2. **Member Date of Birth** = the member's date of birth whose information will be disclosed.
3. **Blue Cross NC ID Number** = this is the Blue Cross Member ID number from the insurance card.
4. **Member Address** = address for the member whose information is being disclosed.
5. **Authorized Representative(s) Name, Address, Phone and Relationship to Member** = this information should be for the person who you are designating as the representative to disclose your PHI to.
6. **Relationship to Member** = list the relationship of the person who you are authorizing as a representative as Power of Attorney or other category, see information below under "Personal Representatives"
7. **Type of PHI** = indicate the type of PHI you would like to authorize this person or entity to receive which are underneath the statement "I authorize the Plan and their business associates to disclose the following PHI..." If you check the box for "Any information requested," this means that the person you are authorizing may receive any of your PHI that they request.
8. **When This Authorization Expires** = please indicate a date after the statement "I would like this authorization to expire on:" **Or**, you may check the box "when my coverage expires".
9. **Your Signature** = you must sign your own authorization form unless you are the legal personal representative (see below) or the parent of a minor child who is giving the authorization.
10. **Date.** The date you sign the authorization form must be filled in the blank next to your signature.

Personal Representatives. A personal representative is a person who has legal authority to make decisions for the member / dependent. If a personal representative is signing for the member / dependent, the personal representative must state their authority to sign in the blank spaces below the signature line. If the personal representative is not a parent, then the document(s) giving the personal representative legal authority to sign must be on file with the State Health Plan or its Claims Processing Contractor, Blue Cross and Blue Shield of North Carolina, for the Plan to accept the request (if already submitted and valid, you do not need to submit new forms). If you are a parent of minor child, please submit Birth Certificate or Adoption Decree. All other Personal Representatives should send appropriate legal documentation. A Health Care Power of Attorney is NOT a valid document for this purpose if it does not contain language authorizing the disclosure of PHI. If you are unsure what documentation to send, please call Customer Service = Monday-Friday 8 am - 6 pm at **888-234-2416**.

BlueCross BlueShield of North Carolina

Non-Discrimination and Accessibility Notice

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified interpreters and/or written information in other formats (large print, accessible electronic formats, etc.)
- Free language services to people whose primary language is not English, such as: qualified interpreters and/or information written in other languages

If you need these services, call the Customer Service or TTY number on the back of your member ID card.

If you believe that Blue Cross NC 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:

Blue Cross NC, P.O. Box 2291, Durham, NC 27702
Attention: Civil Rights Coordinator-Privacy,
Ethics & Corporate Policy Office
Call: 919-765-1663, 1-888-291-1783 (TTY)
Fax: 919-287-5613
Email: civilrightscoordinator@bcbsnc.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Coordinator-Privacy, Ethics & Corporate Policy Office 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:

Online: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Mail: U.S. Department of Health & Human Services
200 Independence Avenue, SW Room 509F
HHH Building Washington, D.C., 20201
Call: 1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available online at:
http://www.hhs.gov/civil-rights/filing-a-complaint/index.html

This notice and/or attachments may have important information about your application or coverage through Blue Cross NC. Look for key dates. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. If you need these services, call the Customer Service or TTY number on the back of your member ID card.

Discrimination is Against the Law

Blue Cross NC 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 NC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

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BlueCross BlueShield of North Carolina

Multi-Language Interpreter Services

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call the Customer Service or TTY number on the back of your member ID card.

ATENCIÓN: Si habla otro idioma, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Servicio de Atención al Cliente al número de teléfono para personas con problemas auditivos (TTY) que figura al dorso de su tarjeta de identificación.

注意：他の言語を話す方は、言語支援サービスを無料でご利用いただけます。
顧客サービスにお電話いただくか、会員IDカードの裏面にあるTTYサービスをご利用ください。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Dịch vụ khách hàng hoặc TTY trên mặt sau thẻ ID thành viên của bạn.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
가입자 ID 카드 뒷면에 있는 고객 서비스 혹은 TTY 번호로 전화해 주십시오.

ATTENTION$_o$: si vous parlez une autre langue, des services d'aide linguistique vous sont proposés gratuitement. Contactez le service clients au numéro figurant au dos de votre carte de membre.

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم خدمة العملاء أو رقم الهاتف النصي الموضح على ظهر بطاقة هوية العضو.

LUS CEEB TOOM:Yog tias koj hais lus Hmoob, , peb muaj kev pab txhais lus pub dawb rau koj. Hu rau Customer Service tus xov tooj los yog tus xov tooj TTY rau cov neeg tsis hnov lus zoo uas nyob sab tom qab koj daim npav ID.

ВНИМАНИЕ: Если вы говорите на другом языке, то вам доступны бесплатные услуги перевода. Позвоните в Отдел обслуживания по номеру, указанному на обратной стороне вашей идентификационной карточки участника.

PAUNAWA: Kung nagsasalita ka ng ibang lengguwahe, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tawagan ang numero ng Customer Service o TTY sa likod ng iyong member ID card.

સૂચના: જો તમે ગુજરાતી બોલતા હોવ તો તમારા માટે ભાષા સેવાઓ નિ:શુ ક ઉપલ ધ છે. તમારા સ યપદ ઓળખપ ત્રની (આઈ.ડી) પાછળની બાજુ પર આપેલ ગ્રાહક સેવાઓના નંબર અથવા TTT નંબર પર કૉલ કરો.

ចំណាំ៖ ប្រសិនប្រាកអ្នកនិយាយជាភាសាខ្មែរ បសវាកមជំនួយម្តភាសាមានផ្តល់ជូនសបមាប្រាកអ្នកដោយមិនគិតថ្លៃ។សូមបៅបៅកា ន់បស វាអតិ្ថជនដោយបប្របលទូរស័ព្ទបៅខាងលើកាតសមាជិកប្រស់បោកអ្នក។

ACHTUNG: Falls Sie eine andere Sprache sprechen, stehen Ihnen kostenlose Sprachdienste zur Verfügung. Rufen Sie die Nummer des Kundenservices oder von TTY an, die auf der Rückseite Ihrer Mitgliedskarte angegeben ist.

ध्यान दें: यदि आप दूसरी भाषा बोलते हैं, तो आपके लिए भाषा सहायता सेवाएं, मुफ्त में, उपलब्ध हैं। अपने सदस्य आईडी कार्ड के पीछे मौजूद ग्राहक सेवा या TTY नंबर पर कॉल करें।

ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາອື່ນ, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ໄດ້ເສຍຄ່າ.
ໂທຫາຝ່າຍບໍລິການລູກຄ້າຫລື ເບີ TTY ຢູ່ດ້ານຫຼັງບັດປະຈຳຕົວຂອງທ່ານ.

注意：如果您講廣東話或普通話， 您可以免費獲得語言援助服務。請撥打您會員 ID 卡背面的客服或 TTY號的電話號碼。

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