Basic Blue® Rx (PDP)
A Medicare Prescription Drug Plan

Authorization to Release Information

Use this form when you want Basic Blue® Rx (PDP) to release your Protected Health Information (PHI) to a person or organization on your behalf, such as a family member, friend or employer/former employer.

Questions?

Call **1-877-376-2185,** 8 a.m. to 8 p.m., daily, local time. TTY hearing impaired users should call **711**.

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Basic Blue Rx Authorization to Release Information

Section A: Member information (person granting release of information)

Member name: ____

Address: ____

Telephone: (______)________________ Member ID Number: __________________________________

Please read the following and complete the information requested.

No conditions: This authorization is voluntary. We will not condition your enrollment in a health plan or eligibility or payment for benefits on receiving this authorization.

Effect of granting this authorization: The Protected Health Information (PHI) described below may be disclosed to and/or received by persons or organizations who are not subject to federal health information privacy laws. These persons or organizations may further disclose the PHI, and it may no longer be protected by federal health information privacy laws.

Psychotherapy notes: Federal law says that Psychotherapy notes cannot be released using the same authorization form as other records. In order to release Psychotherapy notes, you need to fill out a separate authorization form.

Purpose of release of information: The PHI described below may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, administration of my Basic Blue Rx benefits, or other purposes as I may direct.

Section B: I authorize Basic Blue Rx to release the following information:

(Check one or more box(es) and fill in the blanks, if applicable. Specifically, and meaningfully describe your PHI that you are allowing to be disclosed.)

I SPECIFICALLY AUTHORIZE the release of my Protected Health Information consistent with the description above. (If the information relates to diagnosis or treatment of alcoholism or drug dependency, you must provide the name of the treatment facilities or program(s).)

☐ Address, date of birth, membership status

☐ Claim information for service with (provider name) ________________________ for dates of service from ___________________ to ___________________

☐ Premium information

☐ Psychotherapy notes (see information above)

☐ Information necessary to help me understand my benefits and resolve billing issues, benefits disputes, and other matters

☐ Other (specify the information and types of information to be released):

____

____

Section C: If this release involves a claim or an appeal, select where your claim notices and member payments are sent (leave blank if this does not apply to you):

☐ I want all claim notices, appeal-related correspondence and member payments for these claims sent to the person I have named below. I understand that by checking this box, the information will not be sent to the address in my membership record.

☐ I do not want all claim notices, appeal-related correspondence and member payments for these claims sent to the person named below. These will be sent to the address in my membership record.

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION

Section D: Persons or organizations authorized to receive and use my Protected Health Information:

☐ Name or specifically identify the persons and/or organizations (or the classes of persons and/or organizations) you are allowing to receive and use the PHI described above:

_______________________________________ _______________________________

Name or Title within Organization | Phone Number

____

Address (Street, City, State, ZIP code)

☐ This person is my authorized representative.

☐ Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations) you are allowing to disclose the PHI described above (check at least one box and fill in the blank, if applicable):

☐ Basic Blue Rx

☐ Other persons/organizations:

____

____

Briefly describe the purpose of the disclosure: _______________________________________

____

Section E: Expiration and revocation

Expiration: This authorization will expire one year from the date the authorization is signed, or check a box and complete the blanks, as applicable:

☐ On (insert date) _____ / _____ / _____

☐ When a particular matter is resolved (specify the matter, for example, "Claim for February 2018 prescriptions"):____

☐ When my Basic Blue Rx coverage is terminated

Right to Revoke: I understand that I may cancel this authorization in writing at any time, but it will not affect any release of any information processed before I cancel it. Written cancellation notices should be sent to the address on the back of this form.

Section F: Signature

If the information relates to diagnosis or treatment of alcoholism or drug dependency, I understand that the person(s) I have named to receive the information must treat it as confidential. The information cannot be disclosed again without another signed authorization from me. For all information other than diagnosis or treatment of alcoholism or drug dependency, I understand that the person(s) I have named to receive information may not be subject to privacy laws. They may be able to release the information and privacy laws may no longer protect it.

I, ____, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization for the use and/or disclosure of my Protected Health Information, as described in this form.

Signature: ____ Date: _______________

If this authorization is signed by an authorized representative, complete the following:

Authorized Representative's Name: ____

Relationship to Individual:____

(An Authorized Representative must provide documentation of legal status, such as Power of Attorney.)

Authorization to Release Information instructions

If you would like Basic Blue Rx to release your PHI to a person or organization on your behalf, such as a family member, friend or employer/former employer, you need to fill out and sign this Authorization to Release Information form. Please review and fill out the entire form. If you have any questions, please contact Customer Service at **1-877-376-2185,** 8 a.m. to 8 p.m., daily, local time. TTY users should call **711**.

- **Section A: Member information:** Include your name, address and member identification number. Your telephone number is optional, but may make any follow-up communications with you easier.
- **Section B: Authorization to release information:** Check the box or boxes that apply to the type of PHI you want to disclose. Note that if the information relates to the diagnosis or treatment of alcoholism or drug dependency, you must also provide the name of the treatment facilities or program(s). If it concerns psychotherapy notes in addition to other information you want released, you must complete a separate form for the psychotherapy notes. If you check "Other," please describe the type(s) of your PHI you are allowing to be disclosed.
- **Section C: If the release involves a claim or appeal:** Decide if you want us to send your claim notices and any member payment for the claims to the person you authorize, or if you want to continue having the information sent to the address on your membership record.
- **Section D: Persons or organizations authorized to receive Protected Health Information:** Identify the person or organization that may receive and use your PHI. If you want Basic Blue Rx to disclose your PHI to a person or organization on your behalf, such as a family member, friend or employer/former employer, you must check the plan name box and write the name, phone number and address of the person or organization here. If the person is also your authorized representative and has legal documents that prove that relationship, also check that box. If you check the second box, please list other persons or organizations who you are allowing to disclose your information.
- **Section E: Expiration and revocation:** The authorization will expire automatically one year from the date you sign the form unless you include a different expiration date or occurrence.
- **Section F: Signature:** Print your name in the first blank, sign, date and return the completed authorization form to the following address:

  Basic Blue Rx
  Attention: Privacy Officer
  PO Box 3566
  Scranton, PA 18505
  Fax: **1-855-322-0718**

  If you are the Authorized Representative: An Authorized Representative is a person with authority under state law to make health care decisions on behalf of an individual. Basic Blue Rx will need documentation of that legal status to process an authorization signed by an Authorized Representative.

MII Life Insurance, Inc. is the underwriter for Basic Blue Rx, a prescription drug plan with a Medicare contract. Enrollment in Basic Blue Rx depends on contract renewal. MII Life Insurance, Inc. and each Blue Cross® and/or Blue Shield® plan are independent licensees of the Blue Cross® and Blue Shield® Association.