Anthem BlueCross BlueShield

Date

Name
Address

Necesitamos su autorización antes de que podamos divulgar sus registros a otros. Solo tiene que llenar y firmar este formulario.

Estimado(a) miembro:

Antes de que podamos divulgar sus registros, necesitamos que llene el formulario que viene con esta carta. Luego devuélvanoslo. Este formulario nos informará a quién podemos darle sus registros.

El formulario será válido por un año desde la fecha en que lo firma. Esto es a menos que usted pida que finalice más temprano.

Asegúrese de llenar todo el formulario. Conserve una copia para sus registros. No cambie el formulario ni omita cosas. Si hay problemas o si tenemos preguntas, le enviaremos una carta o le llamaremos.

Una vez recibamos su formulario firmado, lo procesaremos rápidamente. Si tiene alguna pregunta, llame a nuestro Centro de Atención al Cliente al 1-866-408-6131 (Hoosier Healthwise y Healthy Indiana Plan) 1-844-284-1797 (Hoosier Care Connect); (TTY 1-866-408-7188). Pida hablar con la Unidad del Privacidad del Miembro.

Atentamente,

Unidad de Privacidad del Miembro
Anthem Blue Cross and Blue Shield

We can translate this free of charge. Call 1-866-408-6131 (Hoosier Healthwise and Healthy Indiana Plan) 1-844-284-1797 (Hoosier Care Connect); TTY 1-866-408-7188.

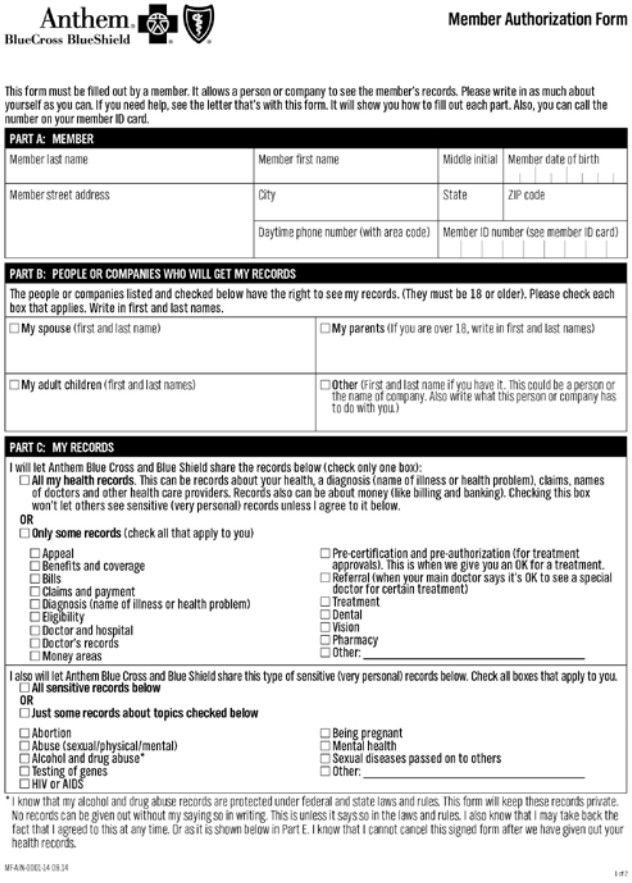
Podemos traducir esta información sin costo. Llame al 1-866-408-6131 (Hoosier Healthwise y Healthy Indiana Plan) 1-844-284-1797 (Hoosier Care Connect); TTY 1-866-408-7188.

www.anthem.com/inmedicaid

Atendiendo al Hoosier Healthwise, Healthy Indiana Plan y Hoosier Care Connect

Lea lo siguiente para obtener ayuda para completar la página uno del formulario.

PARTE A: Miembro



Anthem BlueCross BlueShield

Member Authorization Form

This form must be filled out by a member. It allows a person or company to see the member's records. Please write in as much about yourself as you can. If you need help, see the letter that's with this form. It will show you how to fill out each part. Also, you can call the number on your member 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)	

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. (They must be 18 or older). Please check each box that applies. Write in first and last names.

☐ **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 Anthem Blue Cross and Blue Shield share 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. Records also can be about money (like billing and banking). 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
- ☐ Bills
- ☐ Claims and payment
- ☐ Diagnosis (name of illness or health problem)
- ☐ Eligibility
- ☐ Doctor and hospital
- ☐ Doctor's records
- ☐ Money areas
- ☐ Pre-certification and pre-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
- ☐ Dental
- ☐ Vision
- ☐ Pharmacy
- ☐ Other: _____

I also will let Anthem Blue Cross and Blue Shield 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*
- ☐ Testing of genes
- ☐ HIV or AIDS
- ☐ Being pregnant
- ☐ Mental health
- ☐ Sexual diseases passed on to others
- ☐ Other: _____

* 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 below in Part E. I know that I cannot cancel this signed form after we have given out your health records.

MFAIN-0001-14 09.14

1. Escriba en letras de imprenta su apellido, nombre y la primera letra de su segundo nombre.
2. Escriba su fecha de nacimiento así: mm/dd/aaaa. Así que si nació el 5 de octubre de 1960, usted escribiría 10/05/1960.
3. Escriba su dirección residencial completa, ciudad, estado y código postal.
4. Escriba un número telefónico diurno (incluyendo código de área) donde se puedan comunicar con usted.
5. Número de ID del miembro. Este número está en su tarjeta de identificación de miembro.

PARTE B: Personas o compañías que recibirán mis registros

6. Después de marcar la casilla de la persona o compañía que puede ver sus registros, haga esto. Díganos el nombre completo de la persona o compañía a quien darle sus registros. No utilice un término general como **mi hija** o **mi hijo**. Usted debe ser muy claro.
7. Si marca **Otra persona o compañía**, proporcione:
   - El nombre y apellido (si los tiene).
   - El nombre de la compañía (si le aplica) y su relación con usted.

PARTE C: Mis registros

Díganos cuáles registros nos permitirá divulgar: todos o solo algunos.

8. Para divulgar todos sus registros, marque la primera casilla.
9. Para divulgar solo algunos registros, marque la segunda casilla.
10. También hay una parte sobre cosas que usted piensa que son muy personales o muy privadas para usted. Si está de acuerdo en que podemos divulgar estos tipos de registros, marque las casillas que le aplican.

Lea lo siguiente para obtener ayuda para completar la página dos del formulario.

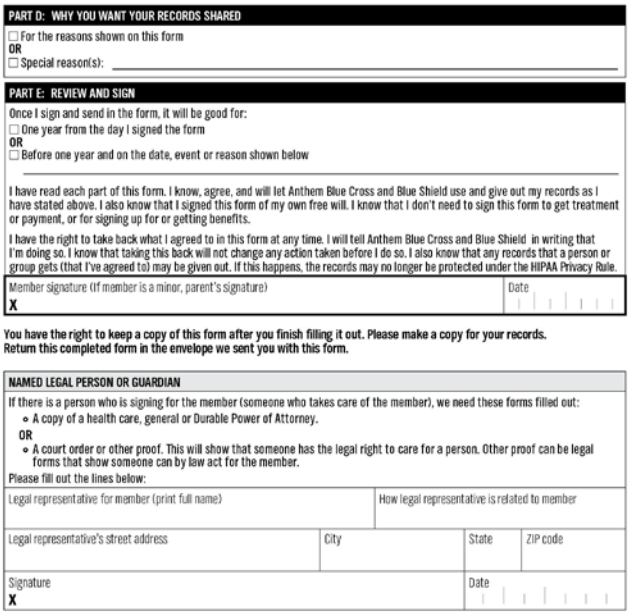
PARTE D: Por qué desea que sus registros sean compartidos

1. La primera casilla nos dice que divulguemos sus registros como se muestra en este formulario.
2. La segunda casilla nos dice un motivo especial. Esto podría ser hablar sobre un reclamo de seguro de salud. Podría ser con un abogado o familiar. Escriba su motivo en el espacio.

PARTE E: Revise y firme

Una vez firme el formulario, el mismo será válido por:

3. Marque la primera casilla para un año. Ese es el tiempo normal.
4. Marque la segunda casilla para decir que el formulario que firma será válido por menos de un año. Luego proporcione la fecha en que desea que termine.
5. **Firme su nombre y ponga la fecha en el formulario.** Su nombre y firma *deben* coincidir con la que escribió en la Parte A.
6. **Si está firmando este formulario para otra persona. Si tiene los formularios que dicen que usted tiene Poder Notarial para cuidado de la salud, o es tutor legal o custodio, debe hacer esto:**
   - Llene **Persona legal o tutor designado.**
   - Denos una copia del formulario legal que muestre que usted tiene Poder Notarial. Póngala con este formulario.



PART D: WHY YOU WANT YOUR RECORDS SHARED

☐ For the reasons shown on this form
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
☐ Before one year and on the date, event or reason shown below

I have read each part of this form. I know, agree, and will let Anthem Blue Cross and Blue Shield 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 Anthem Blue Cross and Blue Shield 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)	Date
X	

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. This will show that someone 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.

Please fill out the lines below:

Legal representative for member (print full name)		How legal representative is related to member	
Legal representative's street address	City	State	ZIP code
Signature X		Date	

Estos son ejemplos de formularios legales. Son usados cuando una persona necesita que alguien más tome decisiones por ellas.

- **Poder notarial general o duradero para cuidado de la salud** Este formulario le da a una persona el poder legal para actuar por usted. Esta persona puede tomar decisiones de cuidado de la salud por usted. El formulario podría decir: para hacerse cargo de mi persona en caso de enfermedad de cualquier clase. También puede decir: y en general para hacer y actuar por mí y en mi nombre todo lo que yo podría hacer si no estoy ahí.
- **Tutoría legal.** Esto es cuando la corte nombre a alguien para que cuide a una persona.
- **Custodia.** Esto ocurre cuando un juez designa a una persona para que esté a cargo. Podría ser cuando una persona no puede tomar decisiones por sí misma.
- **Ejecutor testamentario.** Este tipo de formulario será usado cuando la persona de que se está hablando ha fallecido.

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Signature **X**	Date | | | | | | | |