Medicare Advantage
Member's Designation of an Authorized Representative

I appoint the individual listed below to act as my representative in connection with my claim, grievance or asserted right under Title XVIII of the Social Security Act (the Act) and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance or request wholly in my stead. I understand that personal medical information related to my request may be disclosed to the representative indicated below.

The member named below should be the person signing this designation and consenting to the release of information. If the member is a minor, a parent or legal guardian must sign. If the member is unable to sign for any other reason, a legal representative must sign the designation and submit documentation to verify the authority to sign.

A. MEMBER INFORMATION

Member's Name: _____

Member's ID#:_____

Address: _____Phone Number: _____

B. AUTHORIZED REPRESENTATIVE INFORMATION

Name of Person: _____

I am a /an_____
(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Address:_____ Phone Number: _____

C. INFORMATION THAT BLUE CROSS MAY DISCLOSE

Please read this important information.

By checking the box below, I grant Blue Cross permission to discuss with or disclose to my authorized representative on my behalf:

☐ **All my information**: This may include a *diagnosis* (name of illness or condition), *procedure* (type of treatment), *claims*, *doctors* and *other health care providers*, and *financial information* (like billing and banking). **This also includes the following information (see below).**

- Appeals and Grievances
- Benefits and Coverage
- Billing
- Claims and Payment
- Dental
- Diagnosis and Procedure
- Eligibility and Enrollment
- Financial
- Medical Records
- Pharmacy

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❖ **Sensitive information**. I approve the disclosure of the following types of sensitive information by Blue Cross (check all boxes that apply):		
❑ HIV or AIDS	❑ Mental or behavioral health	❑ Alcohol and substance abuse ***(*Member must designate specific reason for disclosure of this sensitive information.)***

***If alcohol and substance abuse list reason for disclosure**

☐ to assist with claim(s) payment (including FSA, HRA, HSA, and Coordination of Benefits) ☐ coordination of care ☐ assist with treatment ☐ Other (specify): _____

D. MEMBER AND AUTHORIZED REPRESENTATIVE SIGNATURE AND DATE

I have read the contents of this form. I understand, agree, and allow Blue Cross to discuss and/or disclose my information as I have stated on the previous page. I understand that Blue Cross does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or eligibility benefits. I understand I am entitled to a copy of this form and agree that a photocopy is as valid as the original.

I understand this designation is valid for 1 year. I may revoke this designation at any time within the year by notifying Blue Cross in writing at the address below. I understand that a revocation will not apply to information that was already disclosed. I understand that once information has been disclosed according to these instructions, the Health Insurance Portability and Accountability Act (HIPAA) and other privacy laws may no longer protect the information.

MEMBER SIGNATURE:	**AUTHORIZED REPRESENTATIVE SIGNATURE:**
_____	_____
Print Name: _____ Date: _____	I, (Print Name) _____, hereby accept the Appointment of Representation. Date: _____

Blue Cross may request information, now or in the future, as it deems necessary to confirm authorized representative status.

Mail or fax this completed form to:

Mail: Blue Cross Blue Shield of Massachusetts Medicare Advantage Correspondence
P.O. Box 55007
Boston, MA 02205-5007

Fax: 1-617-246-8506

If you have any questions, please call us at 1-800-200-4255, 8:00 a.m. to 8:00 p.m. Eastern Time, seven days a week except April 1 through September 30 when we are open Monday through Friday. TTY users should call 711.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity.
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Llame al **1-800-200-4255** (TTY: **711**).
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis.
Ligue para **1-800-200-4255** (TTY: **711**).

Please keep a copy of this form for your records.

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