Medicare Advantage
Member's Designation of an Authorized Representative

An *authorized representative* is someone chosen by a member to assist the member with health care issues, and to whom Blue Cross Blue Shield of Massachusetts (Blue Cross) is allowed to disclose and discuss the member's protected health information. An authorized representative is not, however, a person who has legal authority to act on behalf of a member. Use this form to designate an authorized representative to speak to Blue Cross on your behalf and to provide access to your information as shown 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#:_____Date of Birth: _____

Address: _____Phone Number: _____

B. AUTHORIZED REPRESENTATIVE INFORMATION

Name of Person: _____

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

Date of Birth: _____Address:_____

C. INFORMATION THAT BLUE CROSS MAY DISCLOSE

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
- HIV or AIDS
- Mental or Behavioral Health
- Alcohol and Substance Abuse

Continue to next page >

D. MEMBER AND LEGAL 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. I may revoke this designation at any time by notifying Blue Cross in writing at the address provided 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:	**LEGAL REPRESENTATIVE SIGNATURE:**
Print Name: _____ Signature: _____ Date: _____	I, (Print Name) _____, hereby accept the Appointment of Representation. Signature:_____ 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 questions, please call our Member Service Department, Monday through Friday from February 15th through September 30th and Monday through Sunday from October 1st through February 14th, from 8:00 a.m. to 8:00 p.m., at **1-800-200-4255**, or for the hearing impaired at TTY **711**.

Blue Cross Blue Shield of Massachusetts is an HMO and PPO plan with a Medicare contract.
Enrollment in Blue Cross Blue Shield of Massachusetts depends on contract renewal.

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.