Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

Contact Information
Phone: **1-800-200-4255** TTY: **1-800-522-1254** Hours: From February 15th to September 30: **Monday-Friday 8am-8pm** From October 1st to February 14th : **Monday-Sunday 8am-8pm** Mail: **P.O. Box 55007** **Boston, MA** **02205-5007**

Member's Designation of a Personal Representative

Please use this form to authorize Blue Cross Blue Shield of Massachusetts, Inc. (BCBSMA) to provide the Personal Representative named with unlimited access to the member's information.

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.

Member's Name:_____ Member's ID#_____ Date of Birth:_____

Address:_____ Daytime Phone Number: _____

_____

The following individual is designated to act as Personal Representative:

Name:_____

Address: _____ Daytime Phone Number: _____

_____

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Scope of Designation: The individual named as my Personal Representative may act on my behalf in regard to health care coverage provided to me through BCBSMA. BCBSMA may respond to questions from my Personal Representative on my behalf and disclose information to my Personal Representative in the same manner and to the same extent that BCBSMA would disclose information to me. This includes any and all claims, medical records and information relating to me (including but not limited to, records related to HIV Testing, AIDS diagnosis or treatment, and mental health). I understand that BCBSMA will send benefit payments due me and written communications regarding my coverage in accordance with BCBSMA's standard practices unless I have specified otherwise in writing.

This designation is valid until I revoke it. I may revoke this designation at any time by notifying BCBSMA in writing. I understand that a revocation will not apply to information that was already released while this designation was in effect. I understand that once information has been released according to these instructions, BCBSMA will not be able to limit the recipient's use or disclosure of the information, and privacy laws may no longer protect the information.

I may receive a copy of the designation and agree that a photocopy is as valid as the original.

Signature: _____ Print Name_____

Date:_____

If not the member, please state your relationship to the member here: _____

Please return this form to:
Blue Cross Blue Shield of Massachusetts Medicare Advantage Correspondence
P.O. Box 55007
Boston, MA 02205-5007