Instructions for Completing the Designation Of Representative/Authorization Form

Use this form to request the release of your health information to another person or company, or to allow a party to act as your Authorized Representative in carrying out a grievance or an appeal.

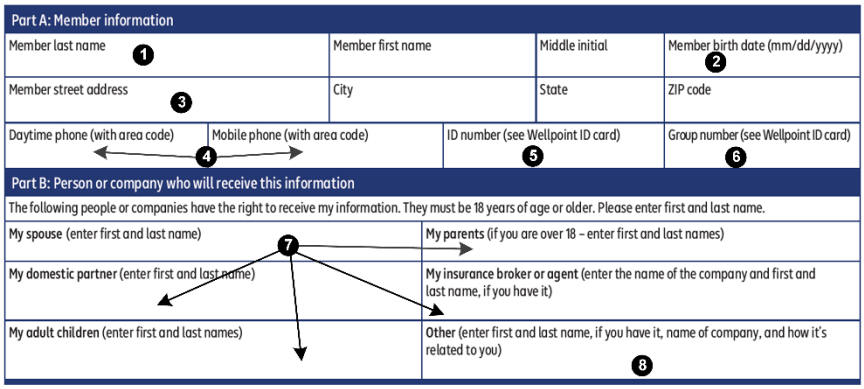
If you have any questions, please feel free to call us at the member services number on your Wellpoint ID card.

Please read the following for help completing the form.

PART A: Member information

This section applies to the member who is asking for the release of his or her information to another person or company, or is appointing an Authorized Representative. Please include as much information as you can.

1. Print your last name, first name, and middle initial.
2. Write your date of birth in this format: mm/dd/yyyy. (If you were born on October 5, 1960, you would write 10/05/1960.)
3. Write your full street address, city, state, and ZIP code.
4. Write your daytime phone number and your cell / mobile number (with area codes).
5. **Identification number** – You'll find this number on your Wellpoint ID card.
6. **Group number** – You'll find this number on your Wellpoint ID card. If your ID card doesn't have a group number, leave this blank.



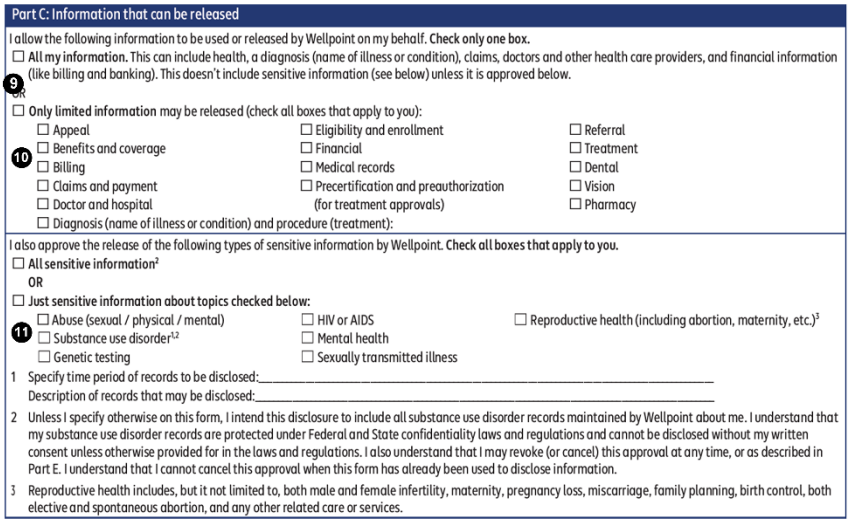
PART B: Person or company who will receive this information

7. Check the box that applies to you. Write the full name of the person or company that you want us to give your information to. Please don't use a general term like "my daughter" or "my son" as it will not be accepted. You need to be specific.
8. If you check **Other**, give the first and last name (if available), the name of the company (if applicable), and how they relate to you.

PART C: Information that can be released

This section tells us what information you would like us to release: all or just some.

9. For all of your information, check the first box (this does not include sensitive information).
10. For limited information, check the second box and the boxes that apply to you.
11. Some topics may be very personal or sensitive to you. If you wish to approve the release of this type of information, check the boxes that apply to you.



PART D: Person or company who can act as my authorized representative

This section tells us who you have given the right to act as your Authorized Representative in carrying out a grievance or appeal. Parts B and C must also be completed to authorize the release of your information.

1. Check the box that applies to you. Write the full name of the person or company that you want to act as your Authorized Representative. Please don't use a general term like "my daughter" or "my son" as it will not be accepted. You need to be specific.
2. If you check **Other**, give the first and last name (if available), the name of the company (if applicable), and how they relate to you.

PART E: Date your approval expires

You have three choices of when you would like this approval to end.

3. Check the first box for the conclusion of the grievance or appeal process.
4. Check the second box for the authorization to expire after one year.
5. Check the third box for an earlier date (please provide details).

PART F: Purpose of this approval

This section tells us the reason you've asked for the release of your information.

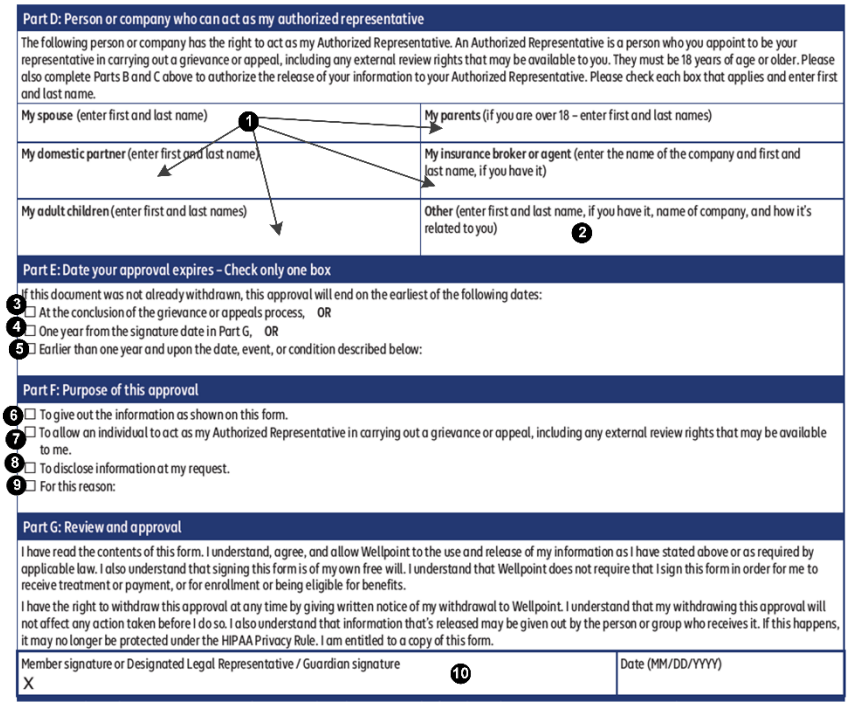
6. Check the first box to confirm that you want to give out your information as specified in this form.
7. Check the second box if you want to release your information to your Authorized Representative for the purposes of a grievance or appeal (identified in Part D).
8. Check the third box to let us know what information to give out (identified in Part C).
9. Check the fourth box to provide a specific reason (for example, to settle a life insurance claim).

PART G: Review and approval

10. **Sign your name and put the date on the form.** Your name and signature must match the information in Part A.

Designated Legal Representative / Guardian

11. **If you are signing this form on behalf of another person, or if you have Power of Attorney for health care, or are a legal guardian/conservator, you must do the following:**
    - Complete the Designated Legal Representative / Guardian section.
    - Provide us with a copy of the legal document showing that you are approved and include it with this form (see the examples in the box at right).



Part D: Person or company who can act as my authorized representative

The following person or company has the right to act as my Authorized Representative. An Authorized Representative is a person who you appoint to be your representative in carrying out a grievance or appeal, including any external review rights that may be available to you. They must be 18 years of age or older. Please also complete Parts B and C above to authorize the release of your information to your Authorized Representative. Please check each box that applies and enter first and last name.

My spouse (enter first and last name) 1	**My parents** (if you are over 18 – enter first and last names)
My domestic partner (enter first and last name)	**My insurance broker or agent** (enter the name of the company and first and last name, if you have it)
My adult children (enter first and last names)	**Other** (enter first and last name, if you have it, name of company, and how it's related to you) 2

Part E: Date your approval expires – Check only one box

If this document was not already withdrawn, this approval will end on the earliest of the following dates:

3 ☐ At the conclusion of the grievance or appeals process, OR

4 ☐ One year from the signature date in Part G, OR

5 ☐ Earlier than one year and upon the date, event, or condition described below:

Part F: Purpose of this approval

6 ☐ To give out the information as shown on this form.

7 ☐ To allow an individual to act as my Authorized Representative in carrying out a grievance or appeal, including any external review rights that may be available to me.

8 ☐ To disclose information at my request.

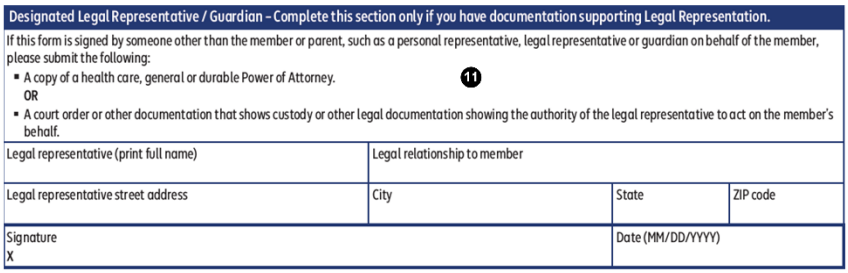
9 ☐ For this reason:

Part G: Review and approval

I have read the contents of this form. I understand, agree, and allow Wellpoint to the use and release of my information as I have stated above or as required by applicable law. I also understand that signing this form is of my own free will. I understand that Wellpoint does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to Wellpoint. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Member signature or Designated Legal Representative / Guardian signature 10 X	Date (MM/DD/YYYY)



Designated Legal Representative / Guardian – Complete this section only if you have documentation supporting Legal Representation.

If this form is signed by someone other than the member or parent, such as a personal representative, legal representative or guardian on behalf of the member, please submit the following:

- A copy of a health care, general or durable Power of Attorney. 11

OR

- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.

Legal representative (print full name)	Legal relationship to member		
Legal representative street address	City	State	ZIP code
Signature X		Date (MM/DD/YYYY)	

Examples of legal documents:

- **Health Care, General or Durable Power of Attorney** – This document gives someone you trust the legal power to act on your behalf and make health care decisions for you.
- **Legal Guardianship** – This is when the court appoints someone to care for another person.
- **Conservatorship** – This happens when a judge appoints a responsible person to make decisions for someone who can't make responsible decisions for him/herself.
- **Executor of estate** – This type of document would be used when the person who is being represented has died.

Wellpoint

Designation of Representative/Authorization Form

For Wellpoint plan members

Use this form to request the release of a member's health information to another person or company, or to allow a party to act as the Authorized Representative in carrying out a grievance or an appeal. Please include as much information as you can.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

Part A: Member information

Member last name	Member first name	Middle initial	Member birth date (mm/dd/yyyy)
Member street address	City	State	ZIP code

Daytime phone (with area code)	Mobile phone (with area code)	ID number (see Wellpoint ID card)	Group number (see Wellpoint ID card)

Part B: Person or company who will receive this information

The following people or companies have the right to receive my information. They must be 18 years of age or older. Please enter first and last name.

My spouse (enter first and last name)	**My parents** (if you are over 18 – enter first and last names)
My domestic partner (enter first and last name)	**My insurance broker or agent** (enter the name of the company and first and last name, if you have it)
My adult children (enter first and last names)	**Other** (enter first and last name, if you have it, name of company, and how it's related to you)

Part C: Information that can be released

I allow the following information to be used or released by Wellpoint on my behalf. **Check only one box.**

☐ **All my information.** This can include health, a diagnosis (name of illness or condition), claims, doctors and other health care providers, and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below.

OR

☐ **Only limited information** may be released (check all boxes that apply to you):

- ☐ Appeal
- ☐ Benefits and coverage
- ☐ Billing
- ☐ Claims and payment
- ☐ Doctor and hospital
- ☐ Diagnosis (name of illness or condition) and procedure (treatment):
- ☐ Eligibility and enrollment
- ☐ Financial
- ☐ Medical records
- ☐ Precertification and preauthorization (for treatment approvals)
- ☐ Referral
- ☐ Treatment
- ☐ Dental
- ☐ Vision
- ☐ Pharmacy

I also approve the release of the following types of sensitive information by Wellpoint. **Check all boxes that apply to you.**

☐ **All sensitive information**[2]

OR

☐ **Just sensitive information about topics checked below:**

- ☐ Abuse (sexual / physical / mental)
- ☐ Substance use disorder[1,2]
- ☐ Genetic testing
- ☐ HIV or AIDS
- ☐ Mental health
- ☐ Sexually transmitted illness
- ☐ Reproductive health (including abortion, maternity, etc.)[3]

1 Specify time period of records to be disclosed:_____

Description of records that may be disclosed:_____

2 Unless I specify otherwise on this form, I intend this disclosure to include all substance use disorder records maintained by Wellpoint about me. I understand that my substance use disorder records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time, or as described in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

3 Reproductive health includes, but it not limited to, both male and female infertility, maternity, pregnancy loss, miscarriage, family planning, birth control, both elective and spontaneous abortion, and any other related care or services.

Part D: Person or company who can act as my authorized representative

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My domestic partner (enter first and last name)	**My insurance broker or agent** (enter the name of the company and first and last name, if you have it)
My adult children (enter first and last names)	**Other** (enter first and last name, if you have it, name of company, and how it's related to you)

Part E: Date your approval expires – Check only one box

If this document was not already withdrawn, this approval will end on the earliest of the following dates:

☐ At the conclusion of the grievance or appeals process, **OR**

☐ One year from the signature date in Part G, **OR**

☐ Earlier than one year and upon the date, event, or condition described below:

Part F: Purpose of this approval

☐ To give out the information as shown on this form.

☐ To allow an individual to act as my Authorized Representative in carrying out a grievance or appeal, including any external review rights that may be available to me.

☐ To disclose information at my request.

☐ For this reason:

Part G: Review and approval

I have read the contents of this form. I understand, agree, and allow Wellpoint to the use and release of my information as I have stated above or as required by applicable law. I also understand that signing this form is of my own free will. I understand that Wellpoint does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to Wellpoint. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Member signature or Designated Legal Representative / Guardian signature X	Date (MM/DD/YYYY)

Designated Legal Representative / Guardian – Complete this section only if you have documentation supporting Legal Representation.

If this form is signed by someone other than the member or parent, such as a personal representative, legal representative or guardian on behalf of the member, please submit the following:

- A copy of a health care, general or durable Power of Attorney.

  OR
- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.

Legal representative (print full name)	Legal relationship to member		
Legal representative street address	City	State	ZIP code
Signature X		Date (MM/DD/YYYY)	

Please return the completed form to: Wellpoint · P.O. Box 4095 · Woburn, MA 01888

Be sure to keep a copy of this form for your records.

For internal use only	Inquiry tracking number: