Wellpoint

Instructions for Completing the Member Authorization Form

If you have any questions, please feel free to call us at the customer service number on your member identification card.

Please read the following for help completing page one of the form.

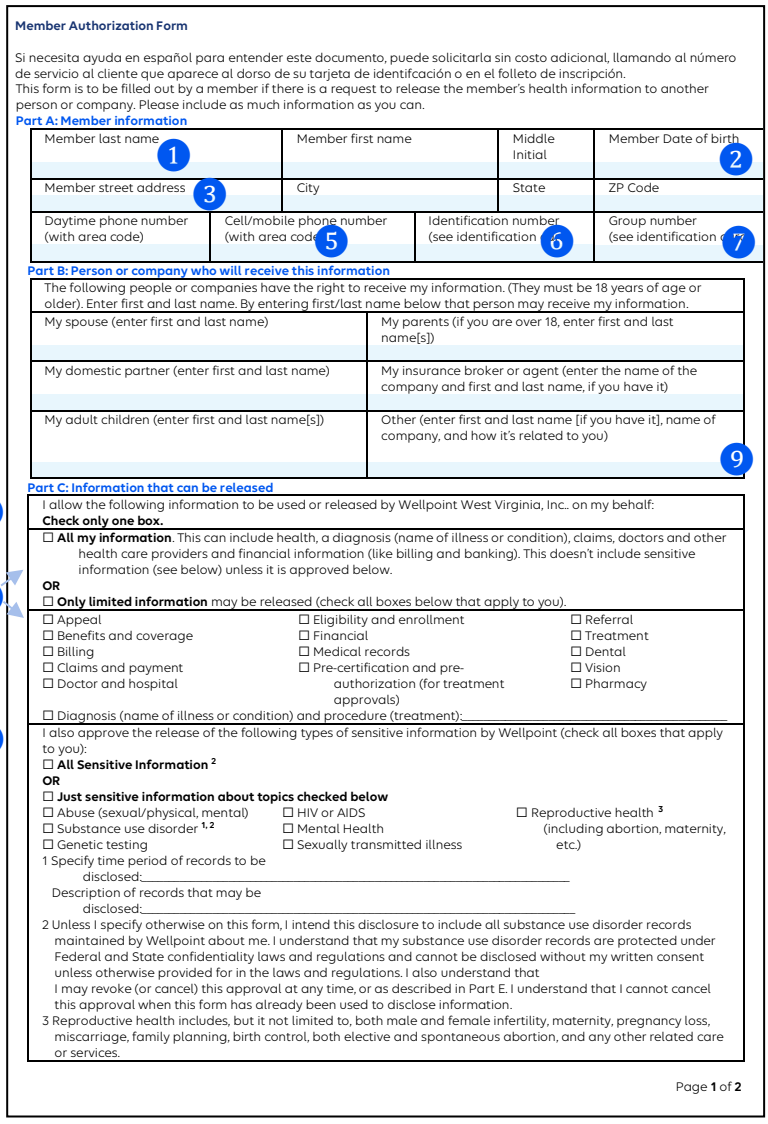
Part A: Member information

This section applies to the member who is asking for the release of his or her information to another person or company.

1. Print your last name, first name, and middle initial.
2. Write your date of birth in this format: mmddyyyy. (If you were born on October 5, 1960, you would write 10051960.)
3. Write your full street address, city, state, and ZIP code.
4. Write your daytime phone number (including area code).
5. Write your cell/mobile number (including area code).
6. **Identification number**
   You will find this number on your member identification card.
7. **Group number**
   You will find this number on your member identification card. If your identification card does not have a group number leave this blank.

Part B: Person or company who will receive this information

8. 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.
9. 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.



Member Authorization Form

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 identifcación o en el folleto de inscripción.
This form is to be filled out by a member if there is a request to release the member's health information to another person or company. Please include as much information as you can.

Part A: Member information

Member last name 1	Member first name	Middle Initial	Member Date of birth 2
Member street address 3	City	State	ZP Code
Daytime phone number (with area code)	Cell/mobile phone number (with area code) 5	Identification number (see identification 6	Group number (see identification 7

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). Enter first and last name. By entering first/last name below that person may receive my information.

My spouse (enter first and last name)	My parents (if you are over 18, enter first and last name[s])
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 name[s])	Other (enter first and last name [if you have it], name of company, and how it's related to you) 9

Part C: Information that can be released

10 I allow the following information to be used or released by Wellpoint West Virginia, Inc.. 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

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

☐ Appeal	☐ Eligibility and enrollment	☐ Referral
☐ Benefits and coverage	☐ Financial	☐ Treatment
☐ Billing	☐ Medical records	☐ Dental
☐ Claims and payment	☐ Pre-certification and pre-authorization (for treatment approvals)	☐ Vision
☐ Doctor and hospital		☐ Pharmacy

☐ Diagnosis (name of illness or condition) and procedure (treatment):_____

12 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)	☐ HIV or AIDS	☐ Reproductive health [3] (including abortion, maternity, etc.)
☐ Substance use disorder [1,2]	☐ Mental Health	
☐ Genetic testing	☐ Sexually transmitted illness	

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.

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Part C: Information that can be released

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

10. For “all of your information,” check the first box.
11. For “limited information,” check the second box and the boxes that apply to you.
12. Some topics may be very personal or sensitive to you. If you wish to approve the release of this type of information, check the box(es) that apply to you.

Please read the following for help completing page two of the form.

Part D: Purpose of this approval

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

1. Check the first box to let us know to give out this information as shown on this form.
2. Check the second box for a specific reason. An example might be to settle a life insurance claim.

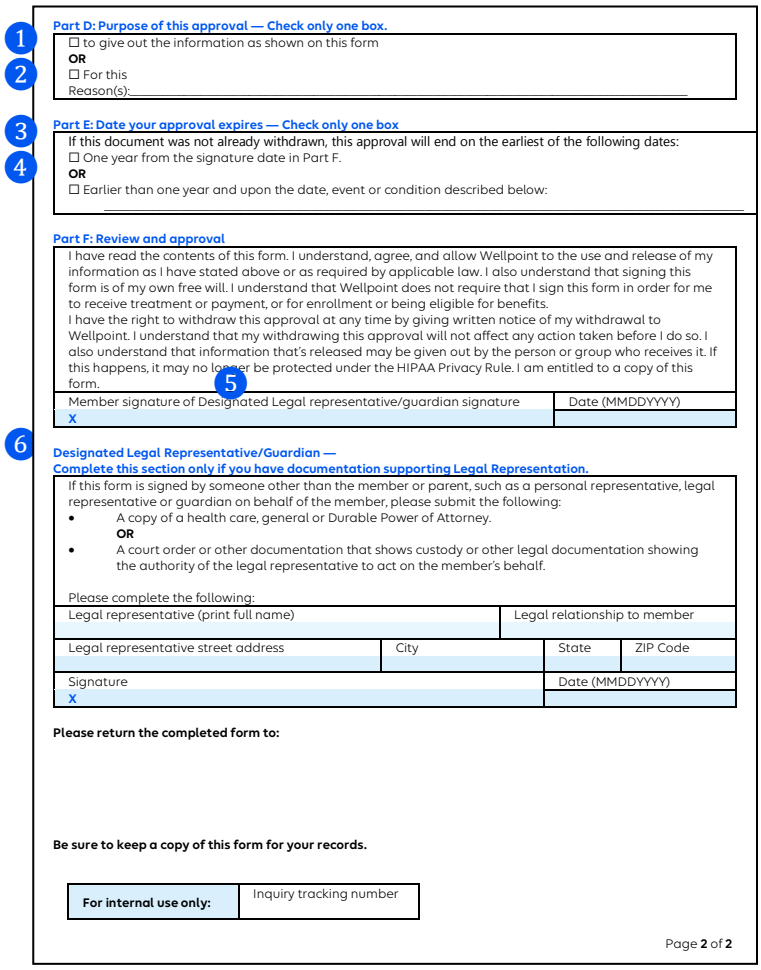
Part E: Date your approval expires

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

3. Check the first box for the standard one year that it will end.
4. Check the second box for an earlier date (other than one year) and give the date you wish this approval to end.

Part F: Review and approval

5. **Sign your name and put the date on the form.** Your name and signature must match the information in Part A.
6. **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:**
   - You must complete the Designated Legal Representative/Guardian section.
   - You must also provide us with a copy of the legal document showing that you are approved and include it with this form.



Part D: Purpose of this approval — Check only one box.

1 ☐ to give out the information as shown on this form

OR

2 ☐ For this Reason(s):_____

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 ☐ One year from the signature date in Part F.

OR

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

_____

Part F: 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.

5 Member signature of Designated Legal representative/guardian signature	Date (MMDDYYYY)
X	

6 **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.

Please complete the following:

Legal representative (print full name)	Legal relationship to member		
Legal representative street address	City	State	ZIP Code
Signature		Date (MMDDYYYY)	
X			

Please return the completed form to:

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

For internal use only:	Inquiry tracking number

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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

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OR
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Legal representative street address	**City**	**State**	**ZIP Code**
Signature		**Date (MMDDYYYY)**	
X			

Please return the completed form to:

HIPAA Team
P.O. Box 9301
Oxnard, CA 93031

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

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