

Do you want us to share your health information with someone?

## Fill Out the Form to Name an Authorized Delegate

For OGB Health Plans

### What Is the Purpose of This Form?

Fill out this form to allow Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc. (collectively called Blue Cross) to share information about your healthcare account with someone else. For instance, you might want us to share your private healthcare information with your spouse, another family member, your child's guardian, your insurance agent, or your employer.

If you fill out and sign this form, we will share your claims or benefit information with anyone you choose. We call the person or organization you choose your *authorized delegate*.

Anyone you name as an authorized delegate will only receive information. They will not be allowed to change anything about your policy unless you also give them the power of attorney.

If you do not fill out this form, we will still continue serving you. We will just not be able to share your information.

Once you send us your completed form, we will share your claims and benefit information with your authorized delegate for as long as you allow us to do so.

Your authorization will be valid as long as you have your health insurance with us. If you cancel your insurance, your authorization will end.

If this authorization covers a minor child, it will end on that child's 18<sup>th</sup> birthday.

#### Still have questions?

Call us. We will be happy to help you.

Call Customer Service at: 1-800-392-4089

### Should You Use This Form?

You should use this form if:

- you are 18 years old or older, or
- your healthcare policy covers a minor child and you want to share that child's information with someone else, or
- you are a member's legal representative and you want to share that member's information with someone else. If you are a legal representative, along with this form, you must send us copies of the documents that prove your legal status.

#### **You must fill out the form. Verbal approval is temporary.**

If you have called us to name an authorized delegate and have received temporary approval from us, you must fill out and sign this form so that your authorized delegate can continue to receive information from us. Your verbal approval is only valid for 2 weeks (14 calendar days) after we talk to you.

### Can You Change Your Decision?

Yes, you may change your decision about sharing your information at any time. If you decide that you no longer want us to share your information with an authorized delegate, write to us.

Withdrawing your permission will not affect any action we take before we receive your letter. In your letter, include a copy of your driver's license so that we can verify your identity.

Fax us at: (225) 298-1590

Call us at: (225) 298-1751

Write to us at: Privacy Office  
Blue Cross and Blue Shield of Louisiana  
P.O. Box 98029  
Baton Rouge, LA 70898-9029



# Name an Authorized Delegate

Fill out this form to allow us to share information about your healthcare account with someone else.  
 If this form is not filled out, we will still continue serving you. We will just not be able to share your information.

## Part 1: Tell Us About Yourself

If you are a member and you want us to share your health information with an authorized delegate, fill out Part 1 about yourself.  
 If you are a legal representative of a member and you want us to share that member's information with someone, fill out Part 1 with the member's information.

<b>Name of member whose information we will share</b> Fill in the member's name as it appears on the member ID card				
<b>Mailing address</b>	Street			
	City	State	ZIP code	
<b>Member ID number as shown on the ID card</b>		<b>OR</b>	<b>Social security number</b>	_____

## Part 2: Tell Us About Your Authorized Delegate

We understand that you want to name the following person or organization as your authorized delegate. *Note:* If the people or organizations you name are not required to follow the federal health information privacy laws, they may share your information with someone else and federal privacy laws may no longer protect your information.

You may change your decision at any time. Withdrawing your permission will not affect any action we take before then. If you no longer want us to share your information with an authorized delegate, write to us. In your letter, include a copy of your driver's license so that we can verify your identity.

<b>To name a person</b>	<b>If your authorized delegate is a person, fill out this section.</b>	<b>Person's name</b>				
		<b>Mailing address</b>	Street			
			City	State	ZIP code	
		<b>Date of birth</b>	____/____/____ MM / DD / YYYY	<b>OR</b>	<b>Driver's license number:</b>	

<b>To name another person</b>	<b>If your authorized delegate is a person, fill out this section.</b>	<b>Person's name</b>				
		<b>Mailing address</b>	Street			
			City	State	ZIP code	
		<b>Date of birth</b>	____/____/____ MM / DD / YYYY	<b>OR</b>	<b>Driver's license number:</b>	

<b>To name an organization</b>	<b>If your authorized delegate is an organization, fill out this section.</b>	<b>Organization name</b>				
		<b>Mailing address</b>	Street			
			City	State	ZIP code	
		<b>Employer Identification Number (EIN)</b>	_____			

### Part 3: Sign Here if You Are the Member

I give Blue Cross permission to share any of my personal information that is protected by federal or state law with the authorized delegates named in Part 2 of this form. I understand that this personal information may have detailed medical information about me, including information about alcohol or drug use and mental health conditions. That information does not include psychotherapy notes, HIV information, or genetic information. (If I want to share that type of information, I will fill out a different form called the *Authorization for the Use/Release of Protected Health Information*. I will call Customer Service for a copy.)

This authorization will be valid until I tell Blue Cross to no longer share my information or until my health insurance with Blue Cross is ended.

My signature

X

Today's date

\_\_\_\_/\_\_\_\_/\_\_\_\_  
MM / DD / YYYY

### Part 4: Sign Here if You Are the Legal Representative for the Member

**To show that you are legally designated as the member's representative, when you send us this form you must also send us copies of any legal documents that prove you have guardianship or power of attorney.**

I am authorized as a personal representative for the member who is named in Part 1 of this form. I am legally designated as a parent of a minor, legal guardian, or holder of power of attorney.

I understand that this authorization will be valid as long as the member's health insurance with Blue Cross is in effect. If the insurance is canceled, the authorization will end.

If this authorization covers a minor child, it will end on that child's 18<sup>th</sup> birthday.

My signature

X

Today's date

\_\_\_\_/\_\_\_\_/\_\_\_\_  
MM / DD / YYYY

My relationship to the member

After you fill out the form, send it to us.

Fax it to us at: (225) 298-7772

Mail it to us at: Customer Service  
Blue Cross and Blue Shield of Louisiana  
P.O. Box 98027  
Baton Rouge, LA 70898-9917

Or  
Email it to us at: [help@bcbsla.com](mailto:help@bcbsla.com)

This email address is not secure.  
There is a small risk that others could see your message.

To keep your information the most private, use our secure online inquiry form at [bcbsla.com/ContactUs](http://bcbsla.com/ContactUs).

#### Still have questions?

Call us. We will be happy to help you.

Call Customer Service at: 1-800-392-4089



Blue Cross and Blue Shield of Louisiana  
HMO Louisiana  
Southern National Life

## **Nondiscrimination Notice**

Discrimination is Against the Law

Blue Cross and Blue Shield of Louisiana and its subsidiaries, HMO Louisiana, Inc. and Southern National Life Insurance Company, Inc., does not exclude people or treat them differently on the basis of race, color, national origin, age, disability or sex in its health programs or activities.

Blue Cross and Blue Shield of Louisiana and its subsidiaries:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (audio, accessible electronic formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, you can call the Customer Service number on the back of your ID card or email **MeaningfulAccessLanguageTranslation@bcbsla.com**. If you are hearing impaired call 1-800-711-5519 (TTY 711).

If you believe that Blue Cross, one of its subsidiaries or your employer-insured health plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you have the right to take the following steps;

### **1. If you are fully insured through Blue Cross, file a grievance with Blue Cross by mail, fax, or email.**

Section 1557 Coordinator  
P. O. Box 98012  
Baton Rouge, LA 70898-9012  
225-298-7238 or 1-800-711-5519 (TTY 711)  
Fax: 225-298-7240  
Email: Section1557Coordinator@bcbsla.com

### **2. If your employer owns your health plan and Blue Cross administers the plan, contact your employer or your company's Human Resources Department. To determine if your plan is fully insured by Blue Cross or owned by your employer, go to [www.bcbsla.com/checkmyplan](http://www.bcbsla.com/checkmyplan).**

Whether Blue Cross or your employer owns your plan, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Or

Electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

# NOTICE

Free language services are available. If needed, please call the Customer Service number on the back of your ID card. Hearing-impaired customers call 1-800-711-5519 (TTY 711).

Tiene a su disposición servicios lingüísticos gratuitos. De necesitarlos, por favor, llame al número del Servicio de Atención al Cliente que aparece en el reverso de su tarjeta de identificación. Clientes con dificultades auditivas, llamen al 1-800-711-5519 (TTY 711).

Des services linguistiques gratuits sont disponibles. Si nécessaire, veuillez appeler le numéro du Service clientèle figurant au verso de votre carte d'identification. Si vous souffrez d'une déficience auditive, veuillez appeler le 1-800-711-5519 (TTY 711).

Có dịch vụ thông dịch miễn phí. Nếu cần, xin vui lòng gọi cho Phục Vụ Khách Hàng theo số ở mặt sau thẻ ID của quý vị. Khách hàng nào bị suy giảm thính lực hãy gọi số 1-800-711-5519 (TTY 711).

我们为您提供免费的语言服务。如有需要，请致电您 ID 卡背面的客户服务号码。听障客户请拨打 1-800-711-5519 (TTY 711)。

الخدمات اللغوية متاحة مجاناً. يرجى، إذا اقتضى الأمر، الاتصال برقم خدمة العملاء المدون على ظهر بطاقة التعريف الخاصة بك. إذا كنت تعاني من إعاقة في السمع، فيرجى الاتصال بالرقم 1-800-711-5519 (TTY 711).

Magagamit ang mga libreng serbisyo sa wika. Kung kinakailangan, pakitawagan ang numero ng Customer Service sa likod ng iyong ID kard. Para sa mga may kapansanan sa pandinig tumawag sa 1-800-711-5519 (TTY 711).

무료 언어 서비스를 이용하실 수 있습니다. 필요한 경우 귀하의 ID 카드 뒤에 기재되어 있는 고객 서비스 번호로 연락하시기 바랍니다. 청각 장애가 있는 분은 1-800-711-5519 (TTY 711)로 연락하십시오.

Oferecemos serviços linguísticos grátis. Caso necessário, ligue para o número de Atendimento ao Cliente indicado no verso de seu cartão de identificação. Caso tenha uma deficiência auditiva, ligue para 1-800-711-5519 (TTY 711).

ພວກເຮົາມີບໍລິການແປພາສາໃຫ້ທ່ານພຣີ. ຖ້າທ່ານຕ້ອງການບໍລິການນັ້ນ, ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຕາມເບີໂທທີ່ຢູ່ທາງຫຼັງຂອງບັດປະຈຳຕົວຂອງທ່ານ. ຖ້າທ່ານຫຼຸບໍ່ດີ, ຂໍໃຫ້ໂທເບີ 1-800-711-5519 (TTY 711).

無料の言語サービスをご利用頂けます。あなたのIDカードの裏面に記載されているサポートセンターの電話番号までご連絡ください。聴覚障害がある場合は、1-800-711-5519 (TTY 711)までご連絡ください。

زبان سے متعلق مفت خدمات دستیاب ہیں۔ اگر ضرورت ہو تو، براہ کرم اپنے آئی ڈی کارڈ کی پشت پر موجود کسٹمر سروس نمبر پر کال کریں۔ سمعی نقص والے کسٹمرز 1-800-711-5519 (TTY 711) پر کال کریں۔

Kostenlose Sprachdienste stehen zur Verfügung. Falls Sie diese benötigen, rufen Sie bitte die Kundendienstnummer auf der Rückseite Ihrer ID-Karte an. Hörbehinderte Kunden rufen bitte unter der Nummer 1-800-711-5519 (TTY 711) an.

خدمات رایگان زبان در دسترس است. در صورت نیاز، لطفاً با شماره خدمات مشتریان که در پشت کارت شناسایی تان درج شده است تماس بگیرید. مشتریانی که مشکل شنوایی دارند با شماره 1-800-711-5519 (TTY 711) تماس بگیرید.

Предлагаются бесплатные переводческие услуги. При необходимости, пожалуйста, позвоните по номеру Отдела обслуживания клиентов, указанному на оборотной стороне Вашей идентификационной карты. Клиенты с нарушениями слуха могут позвонить по номеру 1-800-711-5519 (Телефон с текстовым выходом: 711).

มีบริการด้านภาษาให้ใช้ได้ฟรี หากต้องการ โปรดโทรศัพท์ติดต่อฝ่ายการบริการลูกค้าตามหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของท่าน สำหรับลูกค้าที่มีปัญหาทางการได้ยิน โปรดโทรศัพท์ไปที่หมายเลข 1-800-711-5519 (TTY 711)