STATE OF NORTH CAROLINA TEACHERS' AND STATE EMPLOYEES'
COMPREHENSIVE MAJOR MEDICAL PLAN AND NC HEALTH CHOICE FOR CHILDREN

Instructions For Filling Out The Authorization Request Form

- **Submitting this Authorization Form is Optional.** You do not need to send it unless you want someone else to have access to your protected health information ("PHI") such as your spouse, a family member or friend. This is your choice. Also, you do not need to submit an authorization form in order for the State Health Plan ("Plan") to pay your claims. Submitting this authorization form will not affect your coverage.

- **Only One Person Per Form:** Only one person may give their authorization per form. Also, only one person may be authorized per form to receive PHI.

- **You Must Fill in the Following Information**, on the form otherwise, the Plan cannot accept your authorization request:

    1. **Your Name**: must be filled in the "Member/Dependant Name" blank.

    2. **Your Date of Birth**: must be filled in the "Member/Dependant Date of Birth" blank.

    3. **Your Member I.D. Number**: must be filled in the "Member ID number" blank. This is on your member ID card.

    4. **Your Entire Address**: currently on record must be filled in the "Member/Dependant Address on Record" blank.

    5. **Name of Person or Entity You are Authorizing**: to receive your PHI must be filled in the blank for "Name" which is immediately below the statement "At my request, I authorize the SHP/NCHC and their business associates to disclose my PHI to...."

    6. **Relationship**: The authorized person's or entity's relationship to you must be filled in the blank "Relationship to Member/Dependant."

    7. **The Type of PHI**: you are authorizing this person or entity to receive must be checked in the boxes provided, which are underneath the statement "I authorize the SHP/NCHC and their business associates to disclose the following PHI….." If you check the box for "Any information requested," this means that the person you are authorizing may receive any of your PHI which they request.

    8. **When This Authorization Expires**: should be filled in the blank after the statement "I would like this authorization to expire on…." Or, your may check the box "when my coverage expires".

    9. **Your Signature**: You must sign you own authorization form unless you are the legal personal representative (see below) or the parent of a minor child who is giving the authorization.

    10. **Date**: the date you signed the authorization form must be filled in the blank next to your signature.

- **Personal Representatives**: A personal representative is a person who has legal authority to make decisions for the member/dependant. If a personal representative is signing for the member/dependant, the personal representative must state their authority to sign in the blank spaces below the signature line. If the personal representative is not a parent, then the document(s) giving the personal representative legal authority to sign must be on file with the State Health Plan or its Claims Processor, Blue Cross and Blue Shield of North Carolina for the Plan to accept the request (if already submitted and valid, you do not need to submit new forms).

For more information, please visit our website http://statehealthplan.state.nc.us/ and click on "HIPAA FAQs".

STATE OF NORTH CAROLINA TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN AND NC HEALTH CHOICE FOR CHILDREN

MEMBER/DEPENDENT AUTHORIZATION REQUEST FORM

You may give the State of North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan and NC Health Choice for Children (SHP/NCHC) written authorization to disclose your Protected Health Information (PHI) to anyone you designate and for any purpose. If you wish to authorize a person or entity to receive your PHI, please complete the information below. **Completion of this form will not change the way that the SHP/NCHC communicates with members or dependents. For example, we will still send Explanation of Benefits (EOB) statements to the member.**

Member/Dependent Name _____

Member/Dependent Date of Birth _____/_____/_____ Member ID Number _____

Member/Dependent Address on Record _____

At my request, I authorize the SHP/NCHC and their business associates to disclose my PHI to (enter name of person/entity who will receive your PHI):

_____

(Name) (Relationship to Member/Dependent)

I authorize the SHP/NCHC and their business associates to disclose the following PHI to the person/entity listed above:

- ☐ Enrollment information
- ☐ Benefit information
- ☐ Premium payment information
- ☐ Explanation of Benefits (EOB) information
- ☐ All claims information
- ☐ Any information requested
- ☐ All services from a specific health care provider (list provider's name): _____
- ☐ Other (please list specific PHI): _____

I would like this authorization to expire on (enter date): _____/_____/_____ **OR** ☐ **When my coverage expires**.
(If no expiration date is provided, this authorization will expire twelve (12) months from the date of receipt.)

I understand that I may revoke this authorization at any time by giving the SHP/NCHC written notice mailed to the address at the bottom of this form. I also understand that revocation *will not* affect any action the SHP/NCHC and their business associates took in reliance upon this authorization before receiving my written notice of revocation.

I also understand that the SHP/NCHC *will not* condition the provision of health plan benefits on this authorization.

I further understand that if the persons or entities I authorize to receive my PHI are not health plans, covered health care providers or health care clearinghouses subject to the Health Insurance Portability and Accountability Act (HIPAA) or other federal health information privacy laws, they may further disclose the PHI and it may no longer be protected by HIPAA or federal health information privacy laws.

I also release and discharge the State of North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan and NC Health Choice for Children and their business associates, including Blue Cross and Blue Shield of North Carolina, from any and all liability, cost and claims of whatsoever kind and nature arising from the release of this information.

_____

Signature Date

If signed by a personal representative,

Print your full name: _____

Describe your authority to act for the member (e.g., power of attorney, administrator, parent of minor child, executor of estate, etc):

_____

Note: The SHP/NCHC will consider the effective date of this authorization to be the date the Claims Processing Contractor enters this authorization into its system, typically five days following receipt. If you would like this authorization to become effective on a date after the Claims Processing Contractor enters the authorization into its system, please insert the date here: _____/_____/_____

RETURN THIS AUTHORIZATION TO:

ATTN: HIPAA PRIVACY OFFICER
NC TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN AND NC HEALTH CHOICE
4509 CREEDMOOR ROAD, SUITE 102
RALEIGH NC 27612-3813

Please provide the following information to the person you have authorized so that we may verify the person's identity and authority to receive your PHI: (1) your name, (2) your Member ID number, (3) your date of birth, (4) your address on record, and (5) the type of PHI you have authorized to be released.