Restriction Termination Request

Purpose: This form is used to make a request that your insurer terminate a restriction previously requested and agreed upon. Please check the insurer whose name appears on your health benefits identification card.

_____ CareFirst BlueCross BlueShield* _____ CareFirst BlueChoice _____ Federal Employee Program

Please type or print neatly; we will not process incomplete or illegible forms.

Section A: Individual Whose Information is Subject to the Restriction Agreement

Last Name: _____ First Name: _____ MI: _____

If not the Policy Holder, Name of Policy Holder:

Last Name: _____ First Name: _____ MI: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Phone: (home) _____ (work) _____

Member ID#: _____ Date of Birth: ____/____/_____

Note: This is the number on your health benefits identification card.

Section B: Termination of Restriction Agreement

Date of restriction agreement: ____/____/____ (attach a copy of your Restriction Request and our Agreement).

Effective date of Termination: ____/____/____.

I attest that the above information is correct.

Signature: _____ Date: _____

Print Name:_____

If this request is made by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

☐ A copy of my personal representative form or legal document is on file.

☐ Attached is a copy of my personal representative form or legal document.

Please mail or fax the completed form to:

CareFirst BlueCross BlueShield
Attention: Privacy Office
10455 Mill Run Circle
Owings Mills, MD 21117
Fax: 410-505-6692

Please keep a copy of this request for your records.