ABOUT YOUR PRIVACY

A special notice to our members from Blue Cross Blue Shield of North Dakota (BCBSND)

It is our policy and our obligation under federal and state laws to protect the privacy of our member's information. We need your understanding and cooperation to help ensure compliance with these laws. Before we can disclose information about you to someone acting on your behalf, we need to be sure that we have your permission to do so. The enclosed Authorized Representative Form allows us to use and disclose your health information with designated individuals. We also recommend written authorizations for our members who are between ages 12 and 17.

Although parents and other legal representatives generally have the authority to obtain information about their minor children, there are laws that give minors special protections regarding certain kinds of health information. In these cases, the law requires that we have the written permission of the minor child before we may disclose this information, including to their parents. Without this form, we must do a manual review of a minor's health information to determine what information can be provided to the parents or legal guardian. Because of this manual review, there may be a delay in our response.

If you are a North Dakota resident, this authorization will remain in effect for 18 months past your Plan's termination date. If you are a resident of another state, this authorization will terminate 12 months from the date of signature. For members under age 18, this authorization will terminate as of the member's 18th birthday.

Please contact us at the address and/or phone number printed on the back of your ID card with any questions or changes to information on the form.

INSTRUCTIONS FOR COMPLETION OF THE AUTHORIZATION TO DISCLOSE HEALTH INFORMATION (ADHI)

Section A: Purpose of Form
No information needed.

Section B: Member Information
Please complete all items of information in this section to include your member ID exactly as it appears on your card, full name, address and daytime telephone number where you can be contacted. If the pre-printed information is incorrect, please note changes.

Section C: Authorized Use and/or Disclosure
By completing this form, you are allowing Blue Cross Blue Shield of North Dakota (BCBSND) to use and disclose your protected health information.

Authorized Representative
Indicate the complete name, daytime phone number, address and relationship to you of the person(s) or organization(s) authorized to receive your health information. Note: You may list more than one Authorized Representative. If you wish to list more than two Authorized Representatives, please fill out the additional form.

Section D: Type of Information
You must indicate or describe the information to be disclosed. Check the box that best describes your request.

All My Information*: If you check this box, BCBSND may disclose all information related to the provision of payment for health care benefits or services. If someone is directly involved in coordinating your health care or benefits, you may want them to have access to all your information.

Only Limited Information*: By checking this box, you indicate you want only specific information to be disclosed. Check the appropriate box. If there is not an appropriate box, check the Other box and describe the specific information to be disclosed in the space provided.

*Does not include records protected by 42 C.F.R. Part 2. Requests for use and disclosure of these records should use the Authorization to Release Information Form.

Section E: Expiration and Revocation
This section explains when this authorization will expire. Please check the box only if you want this authorization to terminate in the event of your death.

You may revoke this authorization at any time by sending a written request to Member Services at the address listed on the back of your ID card.

Section F: Signature/Authorization – The individual listed in Section B must sign.
You must print your name, sign and date this form in the spaces provided. If your legal representative (power of attorney or legal guardian) signs this form on your behalf, a copy of the power of attorney or other relevant document evidencing the authority to represent you should be included.

Return completed forms by:

- Portal: Complete and save this form to your desktop to submit through the Member Portal.
  To upload, attach it as part of a request through the Message Center's Contact Us feature.
  When filling out the form please select "General - Other" as your topic.
- Fax: (701) 282-1888
- Mail: BCBSND
  4510 13th Ave S
  Fargo, ND 58121

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION (ADHI) (MEDICAL COVERAGE)

Authorized Representative Form

You are entitled to a copy of this form after you sign it. Please notify us of any changes to the information provided on this form. If you have questions, please call the number on the back of your member ID card.

Return completed forms by:

- Portal: Complete and save this form to your desktop to submit through the Member Portal.
  To upload, attach it as part of a request through the Message Center's Contact Us feature.
  When filling out the form please select "General - Other" as your topic.
- Fax: (701) 282-1888
- Mail: BCBSND
  4510 13th Ave S
  Fargo, ND 58121

Section A: Purpose of Form

This form is used to document the designation of an Authorized Representative(s) for an individual, including a minor who has the right under applicable law to control whether a parent or guardian may have access to the minor's health information. This form authorizes the release of the individual's health information to the Authorized Representative(s) designated on this form.

Section B: Member Information

Please type or print clearly. This individual should sign Section F.

Member ID															Daytime Phone Number		
Last Name				First Name								MI	Suffix	Birth Date (mm/dd/yyyy) / /			
Address																	
City								State				ZIP Code					

Section C: Authorized Use and/or Disclosure

By signing this form, I am allowing Blue Cross Blue Shield of North Dakota to use and disclose my health information with the Authorized Representative(s) designated on this form. I understand that if my Authorized Representative is not subject to federal or applicable state privacy laws, my health information may no longer be protected by those privacy laws and my Authorized Representative may further disclose my health information without my authorization.

Authorized Representative #1 *Must be someone other than self*

Last	First	MI	Suffix	Daytime Phone Number
Address				
City		State		ZIP Code
Relationship to Member in Section B				

Authorized Representative #2 *Must be someone other than self*

Last	First	MI	Suffix	Daytime Phone Number
Address				
City		State		ZIP Code

PLEASE COMPLETE BOTH SIDES OF THIS FORM.
If you have questions, please call the number on the back of your member ID card.
4510 13th Avenue South, Fargo, North Dakota 58121
Blue Cross Blue Shield of North Dakota is an independent licensee of the Blue Cross & Blue Shield Association

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Section C: Authorized Use and/or Disclosure

Relationship to Member in Section B

Section D: Type of Information

I allow the following information to be used or disclosed by BCBSND on my behalf.
Select either "All My Information" or "Only Limited Information." Do not choose both.

☐ **All My Information*** Includes premium, billing, payment, health, diagnosis, claims, doctor and other provider information, including sexually transmitted disease, AIDS, HIV, behavioral, mental health and other sensitive medical information that applicable law may protect.

OR

☐ **Only Limited Information*** By checking this box you indicate you want only specific information to be disclosed. Check the appropriate box. If there is not an appropriate box, check the Other box and describe the specific information to be disclosed in the space provided. (check all that apply)

- ☐ Appeal Information
- ☐ Benefits and Coverage
- ☐ Premium Billing and Payment
- ☐ Claims and Payment
- ☐ Eligibility and Enrollment
- ☐ Pre-certification and Pre-authorization
- ☐ Referral
- ☐ Pharmacy
- ☐ Other _____

*Does not include records protected by 42 C.F.R. Part 2. Requests for use and disclosure of these records should use the Authorization to Release Information Form.

Section E: Expiration and Revocation

For North Dakota residents, this authorization will remain in effect for 18 months past your plan's termination date.
For residents of all other states, this authorization will terminate 12 months from the date of signature below.
If you are under 18 years of age, this authorization will terminate as of your 18th birthday.

☐ By checking this box, I am indicating that I wish this authorization to terminate in the event of my death. If this box is not checked, this authorization will remain valid as indicated above.

I understand that I have the right to revoke or end this authorization at any time. I understand that if I do not wish the person(s) named in Section C to remain my Authorized Representative(s), I must revoke this authorization in writing by giving written notice of my decision to the benefit plan at the address listed on the back of my member ID card. I understand that my revocation of this authorization will not affect any action that you have already taken or any information that you have already released, based upon this authorization before you receive my request to revoke it. I also understand that my revocation may not be effective in preventing release of certain health information to a personal representative, such as a parent, guardian, or person acting in the capacity of a parent or guardian, whom applicable law allows to have access to such health information without my written permission.

Section F: Signature/Authorization

I understand this authorization is voluntary. I understand my treatment, payment, enrollment or eligibility for benefits is not conditioned on receiving this authorization.

I have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization for the use and/or disclosure of my protected health information, as described in this form.

Print Name	
Signature	Date (mm/dd/yyyy)

In accordance with federal regulations, Blue Cross Blue Shield of North Dakota is required to provide you the following disclosure:

Blue Cross Blue Shield of North Dakota complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, gender identity, sexual orientation or sex. Blue Cross Blue Shield of North Dakota does not exclude people or treat them differently because of race, color, national origin, age, disability, gender identity, sexual orientation or sex.

Blue Cross Blue Shield of North Dakota:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides 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, please call Member Services at 1-844-363-8457 (toll-free) or through the North Dakota Relay at 1-800-366-6888 or 711.

If you believe that Blue Cross Blue Shield of North Dakota has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, gender identity, sexual orientation or sex, you can file a grievance with:

Civil Rights Coordinator
4510 13th Ave S
Fargo, ND 58121
701-297-1638 or North Dakota Relay at 800-366-6888 or 711
701-282-1804 (fax)
CivilRightsCoordinator@bcbsnd.com (email) (Communication by unencrypted email presents a risk.)

You can file a grievance in person or by mail, fax, or email within 180 days of the date of the alleged discrimination. Grievance forms are available at http://www.bcbsnd.com/report or by calling 1-844-363-8457. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

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

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*

Español (Spanish)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-363-8457 (TTY: 1-800-366-6888 o 711).

Deutsch (German)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-363-8457 (TTY: 1-800-366-6888 oder 711).

中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-363-8457（TTY：1-800-366-6888 或 711）。

Oroomiffa (Oromo)

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-844-363-8457 (TTY: 1-800-366-6888 ykn 711).

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
Gọi số 1-844-363-8457 (TTY: 1-800-366-6888 hoặc 711).

Ikirundi (Bantu – Kirundi)

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu.
Woterefona 1-844-363-8457 (TTY: 1-800-366-6888 canke 711).

العربية (Arabic)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-363-8457 (رقم هاتف الصم والبكم: 1-800-366-6888 أو711).

Kiswahili (Swahili)

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo.
Piga simu 1-844-363-8457 (TTY: 1-800-366-6888 au 711).

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
Звоните 1-844-363-8457 (телетайп: 1-800-366-6888 или 711).

日本語 (Japanese)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-363-8457
（TTY: 1-800-366-6888 または 711）まで、お電話にてご連絡ください。

नेपाली (Nepali)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस्
1-844-363-8457 (टिटिवाइ: 1-800-366-6888 वा 711) ।

Français (French)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.
Appelez le 1-844-363-8457 (ATS : 1-800-366-6888 ou 711).

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-363-8457
(TTY: 1-800-366-6888 또는 711)번으로 전화해 주십시오.

Tagalog (Tagalog – Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-363-8457 (TTY: 1-800-366-6888 o 711).

Norsk (Norwegian)

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-844-363-8457 (TTY: 1-800-366-6888 eller 711).

Diné Bizaad (Navajo)

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-844-363-8457 (TTY: 1-800-366-6888 éí doodagó 711.)