

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.

Restricted and/or Confidential

4510 13th Avenue South, Fargo, North Dakota 58121

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INSTRUCTIONS FOR COMPLETION OF THE AUTHORIZED REPRESENTATIVE FORM



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

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:

- Fax: (701) 282-1888
- Mail: BCBSND, 4510 13th Ave S, Fargo, ND 58121

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AUTHORIZED REPRESENTATIVE FORM

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



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:

- 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 Blue Cross Blue Shield of North Dakota to use and disclose my health information with 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				
Apartment/Unit/Lot/Suite				
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 use and disclose my health information without my authorization.

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

Last	First	MI	Suffix	Daytime Phone Number
Address				
Apartment/Unit/Lot/Suite				
City		State		Zip Code
Relationship to Member in Section B				

PLEASE COMPLETE ALL PAGES OF THIS FORM.

If you have questions, please call the number on the back of your member ID card.

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Section C: Authorized Use and/or Disclosure

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

Last	First	MI	Suffix	Daytime Phone Number
Address				
Apartment/Unit/Lot/Suite				
City		State		Zip Code
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 health diagnosis, claims, doctors, premium billing and payment information, including maternity, sexually transmitted disease, AIDS, HIV, alcohol, drug or other substance abuse, behavioral and 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 used and disclosed. Check the appropriate box. If there is not an appropriate box, check the Other box and describe the specific information to be used and disclosed in the space provided (*Check all that apply*):
- | | |
|--|--|
| ☐ Appeal information | ☐ Eligibility and enrollment |
| ☐ Benefits and coverage | ☐ Pre-certification and pre-authorization |
| ☐ Premium billing and payment | ☐ Referral |
| ☐ Claims and payment | ☐ Pharmacy |
| ☐ Other: _____ | |

NOTE: Does not include alcohol/substance abuse records protected by 42 C.F.R. Part 2, or psychotherapy notes. 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.

Printed First Name

Printed Last Name

Signature

Today's Date (mm/dd/yyyy)

Blue Cross Blue Shield of North Dakota (BCBSND) 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. BCBSND does not exclude people or treat them differently because of race, color, national origin, age, disability, gender identity, sexual orientation or sex. BCBSND:

- 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 and 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 BCBSND 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) (unencrypted emails present 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 Ave. S.W. 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 con el idioma. También hay disponibles ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles sin cargo. Llame al 1-844-363-8457 (TTY: 1-800-366-6888 o 711) o hable con su proveedor.

Deutsch (German) – ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen kostenfreie fremdsprachliche Unterstützung zur Verfügung. Außerdem sind kostenlos entsprechende Hilfsmittel und Dienstleistungen zur Bereitstellung von Informationen in barrierefreien Formaten erhältlich. Rufen Sie 1-844-363-8457 (TTY: 1-800-366-6888 oder 711) an oder sprechen Sie mit Ihrem Anbieter.

中文 (Chinese) – 注意: 如果您說中文，我們可以為您提供免費的語言協助服務。亦免費提供適當的輔助工具和服務，以無障礙格式提供資訊。請撥打 1-844-363-8457（聽障服務專線 TTY: 1-800-366-6888 或 711）或與您的醫療服務提供者討論。

Oromoo (Oromo) – XIYYEEFFANNOO: Afaan Oromoo dubbattu yoo ta'e, tajaajilli gargaarsa afaan hiikuu kaffaltii malee ni argama. Gargaarsi dabalataa gargaaraadhaaf tajaajilli sirrii ta'ee fi odeeffannoo bifa dhaqqabamaa ta'een kennuunis bilisaan ni argama. Bilbili 1-844-363-8457 (TTY: 1-800-366-6888 or 711) ykn dhiyeessaa kee waliin haasa'i.

Tiếng Việt (Vietnamese) – CHÚ Ý: Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Chúng tôi cũng cung cấp miễn phí các dịch vụ và hỗ trợ bổ sung thích hợp để cung cấp thông tin ở các định dạng dễ tiếp cận. Xin gọi 1-844-363-8457 (TTY: 1-800-366-6888 hoặc 711) hoặc nói chuyện với nhà cung cấp của quý vị.

Ikirundi (Bantu – Kirundi) – Wiyubare: Nimba uvuga Ikirundi, wemerewe ubufasha bwo kuronka ururimi ku buntu. Wemerewe kandi ubufasha bukwiye bw’inyongera na serivisi vyo gutanga amakuru mu buryo bworoshe ku buntu. Hamagara kuri 1-844-363-8457 (TTY: 1-800-366-6888 canke 711) canke uvugane n’ujejwe kugufasha.

(Arabic) العربية – تنبيه: إذا كنت تتحدث العربية، فتتوفر لك خدمات المساعدة اللغوية المجانية. تتوفر أيضًا وسائل وخدمات إضافية مناسبة لتقديم المعلومات بتنسيقات سهلة الاستخدام من دون أي تكلفة. اتصل على الرقم: 1-844-363-8457 (الهاتف النصي: 1-800-366-6888 أو 711) أو تحدث إلى مقدم الرعاية المتابع لك.

Kiswahili (Swahili) – ZINGATIA: Ikiwa unazungumza Kiswahili, huduma za msaada wa lugha bila malipo zinapatikana kwa ajili yako. Vifaa na huduma saidizi zinazofaa ili kutoa taarifa katika miundo inayoweza kufikiwa pia hupatikana bila malipo. Piga simu 1-844-363-8457 (TTY: 1-800-366-6888 au 711) au zungumza na mtoa huduma wako.

Русский (Russian) – ВНИМАНИЕ! Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Также предоставляется дополнительная бесплатная помощь и услуги отображения информации в доступных форматах. Позвоните по телефону 1-844-363-8457 (TTY: 1-800-366-6888 или 711) или обратитесь к своему поставщику услуг.

日本語 (Japanese) – お知らせ: 日本語をお話しになる方は無料の言語アシスタンスサービスをご利用いただけます。情報を利用可能な形式で提供するための適切な補助具やサービスも無料でご利用いただけます。1-844-363-8457 (TTY: 1-800-366-6888 または 711) にお電話いただくか、医療提供者にご相談ください。

नेपाली (Nepali) – ध्यान दिनुहोस्: तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषा सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक प्रविधि र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-844-363-8457 (TTY: 1-800-366-6888 वा 711) मा कल गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

Français (French) – ATTENTION : Si vous parlez français, des services d’assistance linguistique sont disponibles gratuitement. Vous pouvez aussi bénéficier gratuitement de l’accès à des outils et services auxiliaires appropriés dans des formats accessibles. Appelez le 1-844-363-8457 (ATS : 1-800-366-6888 ou 711) ou adressez-vous à votre fournisseur.

한국어 (Korean) – 주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 접근 가능한 형식으로 정보를 제공하는 적절한 보조 수단 및 서비스도 무료로 이용하실 수 있습니다. 1-844-363-8457 (TTY: 1-800-366-6888 또는 711) 번으로 전화하거나 담당 의료 서비스 제공자와 상의하십시오.

Tagalog (Tagalog) – PAUNAWA: Kung nagsasalita kayo ng Tagalog, mayroong kayong magagamit na libreng tulong na mga serbisyo sa wika. Mayroon ding mga angkop na auxiliary na tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format na makukuha ng walang singil. Tumawag sa 1-844-363-8457 (TTY: 1-800-366-6888 o 711) o makipag-usap sa iyong provider.

Norsk (Norwegian) – OBS: Hvis du snakker norsk, er gratis språkhjelp tilgjengelig for deg. Passende ytterligere hjelpemidler og tjenester for å oppgi informasjon i tilgjengelige formater er også tilgjengelig kostnadsfritt. Ring 1-844-363-8457 (TTY: 1-800-366-6888 eller 711) eller snakk med leverandøren din.

Diné (Navajo) – YÁ’ÁT’ÉÉH NITSÁHÁKEES: Díí Diné bizaad bee yáníłt’go, t’áá íiyisí t’áá bee yáhoot’éél dóó baa áháyá’ át’é. T’áá jíík’ehígíí bee na’ách’aq’ holne’ dóó t’áá shikaadéé’ danilí’ígíí t’áá jíík’ehgo bee hólq, dóó t’áá íiyisí doo béésh bee hadooleet da. 1-844-363-8457 bee hojii’ (TTY: 1-800-366-6888 dóó 711), dóó naaltsoos nínízingo bee iiná bee níł hane’ígíí nihíł ch’á hodooll’j’.