Instructions for Completing the Member Authorization Form



If you have any questions, please feel free to call us at the customer service number on your member identification card.

Please read the following for help completing page one of the form.

PART A: MEMBER INFORMATION

This section applies to the member who is asking for the release of his or her information to another person or company.

- Print your last name, first name, and middle initial
- Write your date of birth in this format: mm/dd/yyyy. (If you were born on April 29, 1956, you would write 04/29/1956.)
- Write your full street address, city, state, and ZIP code
- Write your daytime phone number (including area code)
- Identification number
 You will find this number on your member identification card

Group number

You will find this number on your member identification card. If your identification card does not have a group number leave this blank.

PART B: PERSON OR COMPANY WHO WILL RECEIVE THIS INFORMATION

- Check the box that applies to you. Write the full name of the person or company that you want us to give your information to. Please don't use a general term like "my daughter" or "my son" as it will not be accepted. You need to be specific.
- If you check "Other," give the first and last name (if available), the name of the company (if applicable), and how they relate to you.

PART C: INFORMATION THAT CAN BE RELEASED

This section tells us what information you would like us to release: all or just some.

- For "all of your information," check the first box.
- For "limited information," check the second box and the boxes that apply to you.
- Some topics may be very personal or sensitive to you. If you wish to approve the release of this type of information, check the box(es) that apply to you.

Si necesita ayuda en es al cliente que aparece						onal, llamando	al número de servicio
This form is to be filled Please include as much			quest to releas	se the member's he	alth info	rmation to and	other person or company.
PART A: MEMBER INI	FORMATION						
Member last name	Ð	N	Member first nar	те		Middle initial	Member date of birth
Member street address	3	C	ity			State	ZIP code
Daytime telephone num	ber (with area code)	Identific	cation number (s	see identification ca	rd) Gro	up number (see	e identification card)
PART B: PERSON OR	COMPANY WHO WILL	RECEIVE	THIS INFORMA	ATION			
The following people of each box that applies				formation. (They m	ust be 1	.8 years of ag	e or older). Please check
☐ My spouse (enter fi	rst and last name)			My parents (if	you are o	over 18 - enter	first and last name[s])
☐ My domestic partner (enter first and last name)			My insurance broker or agent (enter the name of the company and first and last name, if you have it)				
My adult children (enter first and last name[s])			Other (enter first and last name [if you have it], name of company, and how it's related to you)				
PART C: INFORMATIO	ON THAT CAN BE RELEA	ASED	sed by Buckey	and how it's rela	ited to y	(B)	
PART C: INFORMATIO Lallow the following in All my informating providers and fining approved below. OR Only limited info Appeal Benefits an Billing Claims and Diagnosis (or condition	IN THAT CAN BE RELE. Information to be used on. This can include he ancial information (lik rmation may be releas d coverage payment name of illness name of illness name of illness name of illness	ASED d or releas ealth, a d ke billing sed (check Eligibilit Financia Medical Doctor a	liagnosis (nami and banking). k all boxes belov ty and enrollme al records and hospital	e Health Plan on my e of illness or cond This doesn't includ w that apply to you). ent	behalf ition), cle sensiti	(check only or laims, doctors ive information serval resent me in Standard transfer on macy	
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1-866-246-4358 TTY: 1-800-750-0750

Please read the following for help completing page two of the form.



PART D: PURPOSE OF THIS APPROVAL

This section tells us the reason you've asked for the release of your information.

- Check the first box to let us know to give out this information as shown on this form.
- Check the second box for a specific reason. An example might be to settle a life insurance claim.

PART E: DATE YOUR APPROVAL EXPIRES

You have two choices of when you would like this approval to end.

- Check the first box for the standard one-year that it will end.
- Check the second box for an earlier date (other than one year), and give the date you wish this approval to end.

Your authorization/approval can't be granted for more than one year.

PART F: REVIEW AND APPROVAL

- Sign your name and put the date on the form. Your name and signature must match the information in Part A.
- If you are signing this form on behalf of another person, or if you have Power of Attorney for health care, or are a legal guardian/conservator you must do the following:
 - "" You must complete the Designated Legal Representative/Guardian section.
 - "" You must also provide us with a copy of the legal document showing that you are approved and include it with this form.

\square To give out the information as shown on t \mathbf{OR}	his form		
☐ For this reason(s):			
PART E: DATE YOUR APPROVAL EXPIRES If this document was not already withdrawn	this approval will and an the earliest of	of the following dates:	
□ One year from the signature date in Part F		ii tile tollowilig dates.	
OR □ Earlier than one year and upon the date, e	vent or condition described below		
PART F: REVIEW AND APPROVAL			
I have read the contents of this form. I unde I have stated above. I also understand that s require that I sign this form in order for me t	igning this form is of my own free will. I	understand that Buckeye Healt	h Plan does not
I have the right to withdraw this approval at I understand that my withdrawing this appro that's released may be given out by the pers HIPAA Privacy Rule. I am entitled to a copy o	ival will not affect any action taken befo on or group who receives it. If this happ	ore I do so. I also understand th	at information
Member signature or Designated Legal Represe	ntative/Guardian signature		Date
χ 5			
χ 5			
DESIGNATED LEGAL REPRESENTATIVE/GUARD If this form is signed by someone other than	the member or parent, such as a perso ibmit the following:	nnal representative, legal repres	sentative or
DESIGNATED LEGAL REPRESENTATIVE/GUARD If this form is signed by someone other than guardian on behalf of the member, please su	the member or parent, such as a perso bmit the following: able Power of Attorney. that shows custody or other legal docu	, , ,	
DESIGNATED LEGAL REPRESENTATIVE/GUARD If this form is signed by someone other than guardian on behalf of the member, please su A copy of a health care, general or Dur OR A copyrt order or other documentation i representative to act on the member's Please complete the following:	the member or parent, such as a perso bmit the following: able Power of Attorney. that shows custody or other legal docu	, , ,	ty of the legal
DESIGNATED LEGAL REPRESENTATIVE/GUARD If this form is signed by someone other than guardian on behalf of the member, please s. A copy of a health care, general or Dur OR A court order or other documentation i representative to act on the member's Please complete the following: egal representative (print full name)	the member or parent, such as a perso bmit the following: able Power of Attorney. that shows custody or other legal docu	mentation showing the authori	ty of the legal
DESIGNATED LEGAL REPRESENTATIVE/GUARD If this form is signed by someone other than guardian on behalf of the member, please si A copy of a health care, general or Dur OR A court order or other documentation i	the member or parent, such as a perso bmit the following: able Power of Attorney. that shows custody or other legal docu behalf.	mentation showing the authori	ty of the legal
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DESIGNATED LEGAL REPRESENTATIVE/GUARD If this form is signed by someone other than guardian on behalf of the member, please su A copy of a health care, general or Dur OR A court order or other documentation is representative to act on the member's Please complete the following: Legal representative (print full name) Legal representative street address Signature X Please return the completed form to: Buckeye Health Plan 4349 Easton Way, Suite 120	the member or parent, such as a personal three following: able Power of Attorney. that shows custody or other legal docubehalf. City rrecords.	mentation showing the authori	ty of the legal ber

Examples of legal documents:

- "" **Health Care**, **General or Durable Power of Attorney**. This document gives someone you trust the legal power to act on your behalf and make health care decisions for you.
- "" Legal Guardianship. This is when the court appoints someone to care for another person.
- **"" Conservatorship**. This happens when a judge appoints a responsible person to make decisions for someone who can't make responsible decisions for him/herself.
- **"" Executor of estate**. This type of document would be used when the person who is being represented has died.

1-866-246-4358

Member Authorization Form



Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This form is to be filled out by a member if there is a request to release the member's health information to another person or company. Please include as much information as you can.

PART A: MEMBER INFORMATION							
Member last name		Member first name		Middle initial	Member date of birth		
Member street address		City		State	ZIP code		
Daytime telephone number (with area code) Identif		fication number (see identification card) Gr		Group number (see identification card)			
PART B: PERSON OR COMPANY WHO WILL R	RECEIV	E THIS INFORM <i>a</i>	ATION				
The following people or companies have the righ each box that applies and enter first and last nat		ceive my informa	ition. (They must be 18 y	ears of a	age or older)	. Please check	
☐ My spouse (enter first and last name)			☐ My parents (if you are over 18 - enter first and last name[s])				
☐ My domestic partner (enter first and last name)			☐ My insurance broker or agent (enter the name of the company and first and last name, if you have it)				
☐ My adult children (enter first and last name[s])			□ Other (enter first and last name [if you have it], name of company, and how it's related to you)				
PART C: INFORMATION THAT CAN BE RELEAS	SED						
I allow the following information to be used or re	eleased	d by Buckeye Hea	lth Plan on my behalf (ch	neck only	one box):		
All my information. This can include healt providers and financial information (like bil approved below.	th, a di Iling ar	agnosis (name of nd banking). This (fillness or condition), cla doesn't include sensitive	nims, doc informa	tors and oth tion (see be	er health care low) unless it is	
OR Only limited information may be release	d (che	ck all hoxes helov	w that annly to you)	_ D . C	-1		
☐ Appeal ☐ Benefits and coverage ☐ Billing ☐ Claims and payment ☐	⊒ Eligi ⊒ Fina ⊒ Med ⊒ Doc1 ⊒ Pre-	bility and enrollm ncial ical records tor and hospital	ent [[[[[[] pre-authorization [□ Treatm □ Dental □ Vision □ Pharm	sent me in S nent	tate Hearings/Complaints	
I also approve the release of the following types	of ser	nsitive information	n by Buckeye Health Plar	n (check	all boxes tha	at apply to you):	
☐ All sensitive information							
OR	l helov	W					
☐ Just information about topics checked below ☐ Abortion ☐ Genetic testing ☐ Abuse (sexual/physical/mental) ☐ HIV or AIDS ☐ Alcohol/substance abuse ** ☐ Maternity ** Lunderstand that my clockel/cubstance abuse records are pretented.				ther:	smitted illness		

1 of 2

1-866-246-4358

TTY: 1-800-750-0750

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^{**} I understand that my alcohol/substance abuse records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time, or as described below in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

PART D: PURPOSE OF THIS APPROVAL					
\Box To give out the information as shown on this form					
OR □ For this reason(s):					
PART E: DATE YOUR APPROVAL EXPIRES					
If this document was not already withdrawn, this approval will o	end on the earliest of the	following dates:			
☐ One year from the signature date in Part F	sha on the carnest of the	Tollowing dates.			
OR	and the law				
\square Earlier than one year and upon the date, event or condition d	escribed below				
PART F: REVIEW AND APPROVAL					
I have read the contents of this form. I understand, agree, and a	allow Buckeye Health Plan	to the use and release of	f my information as		
I have stated above. I also understand that signing this form is	of my own free will. I unde	erstand that Buckeye Hea	Ith Plan does not		
require that I sign this form in order for me to receive treatmen					
I have the right to withdraw this approval at any time by giving	•	•			
I understand that my withdrawing this approval will not affect a					
that's released may be given out by the person or group who re HIPAA Privacy Rule. I am entitled to a copy of this form.	ceives it. II tills liappells,	it illay ilo lollger be prote	cteu unuer the		
			Data		
Member signature or Designated Legal Representative/Guardian signature Date					
X					
DESIGNATED LEGAL REPRESENTATIVE/GUARDIAN					
If this form is signed by someone other than the member or par	ent, such as a nersonal re	nresentative, legal renres	sentative or		
guardian on behalf of the member, please submit the following:		p. 000			
 A copy of a health care, general or Durable Power of Attor 	ney.				
OR	, or other legal decuments	ation chawing the authori	ty of the local		
 A court order or other documentation that shows custody representative to act on the member's behalf. 	or utiler legal ducumenta	ation snowing the authorn	ty of the legal		
Please complete the following:					
Legal representative (print full name)	oer				
Legal representative street address	City	St	ate ZIP code		
Signature			Date		
X					
Please return the completed form to:					
Buckeye Health Plan					
4349 Easton Way, Suite 120					
Columbus OH 43219					

Be sure to keep a copy of this form for your records.

FOR RECIPIENT OF SUBSTANCE ABUSE INFORMATION

This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFP part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

For internal use only:	Inquiry tracking number
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Statement of Non-Discrimination

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

Buckeye Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - 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, contact Buckeye Health Plan at 1-866-246-4358 (TTY 1-800-750-0750).

If you believe that Buckeye Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender, or gender identity you can file a grievance with: Buckeye Health Plan at the Appeals Unit, 4349 Easton Way, Suite 120, Columbus, OH 43219, 1-866-246-4358 (TTY:1-800-750-0750), Fax 1-866-719-5404. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Buckeye Health Plan 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, 1-800-368-1019, 800-537-7697 (TDD).

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

1-866-246-4358 TTY: 1-800-750-0750

Language Assistance

English:

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-866-246-4358 (TTY: 711).

Spanish:

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-246-4358 (TTY: 711).

Nepali:

ध्यान दिनुहोस्: तपाई नेपाली बोल्नुहुन्छ भने तपाईंलाई भाषा सहायता सेवा निःशुल्क उपलब्ध गराइन्छ । 1--866--246--4358 (TTY: 711) मा कल गर्नुहोस् ।

Arabic:

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل بالرقم 4358-246-866-1 (رقم هاتف الصم والبكم: 711).

Somali: FIIRO GAAR AH: Hadii aad ku hadasho Soomaali, adeegyada kaalmada luuqada, oo bilaash ah ayaad heleysaa. La hadal 1-866-549-8289 (TTY: 711).

Russian:

ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги языковой помощи. Звоните по номеру 1-866-246-4358 (ТТҮ: 711).

French:

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-246-4358 (ATS : 711).

Vietnamese:

LƯU Ý: Nếu bạn nói tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-866-246-4358 (TTY: 711).

Swahili:

TANGAZO: Ikiwa unazungumza Kiswahili, huduma za msaada wa lugha, zinapatikana kwa ajili yako, bila malipo. Piga simu 1-866-246-4358 (TTY: 711).

Ukranian:

УВАГА! Якщо ви володієте англійською мовою, для вас доступні безкоштовні послуги мовної підтримки. Телефонуйте за номером 1-866-246-4358 (ТТҮ: 711).

Chinese Cantonese:

注意:如果您說中文,您可獲得免費的語言協助服務。請致電 1-866-549-8289 (TTY: 711)。

Kinyarwanda:

ICYITONDERWA: Niba uvuga Icyongereza, serivisi z'ubufasha bw'indimi, ziraboneka ku buntu. Hamagara 1-866-246-4358 (ku bafite ubumuga bwo kutumva: 711).

Chinese Mandarin:

注意: 如果您使用中文,您可以免费获得语言援助服务。请致电 1-866-246-4358 (TTY: 711)。

Afghani:

پاملرنه: كه تاسو انگليسي خبرې كوئ، د ژبې مرستې خدمتونه، وړيا، تاسو لپاره شتون لري. (TTY: 711) 8289-549-1 ته زنګ وو هئ.

Amharic:

ትኩረት፦ አማርኛ የሚናንሩ ከሆነ፣ ለእርስዎ የሚሆኑ ከክፍያ ነጻ የቋንቋ እንዛ አንልግሎቶች አሉን። በ 1-866-246-4358 (TTY: 711) ይደውሉ።

Gujarati:

ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારા માટે, ભાષા સહ્યય સેવાઓ નિઃશુલ્કપણે ઉપલબ્ધ છે. 1-866-246-4358 (TTY: 711) પર કૉલ કરો.