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.

1. Print your last name, first name, and middle initial
2. 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.)
3. Write your full street address, city, state, and ZIP code
4. Write your daytime phone number (including area code)
5. **Identification number**
   You will find this number on your member identification card
6. **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.

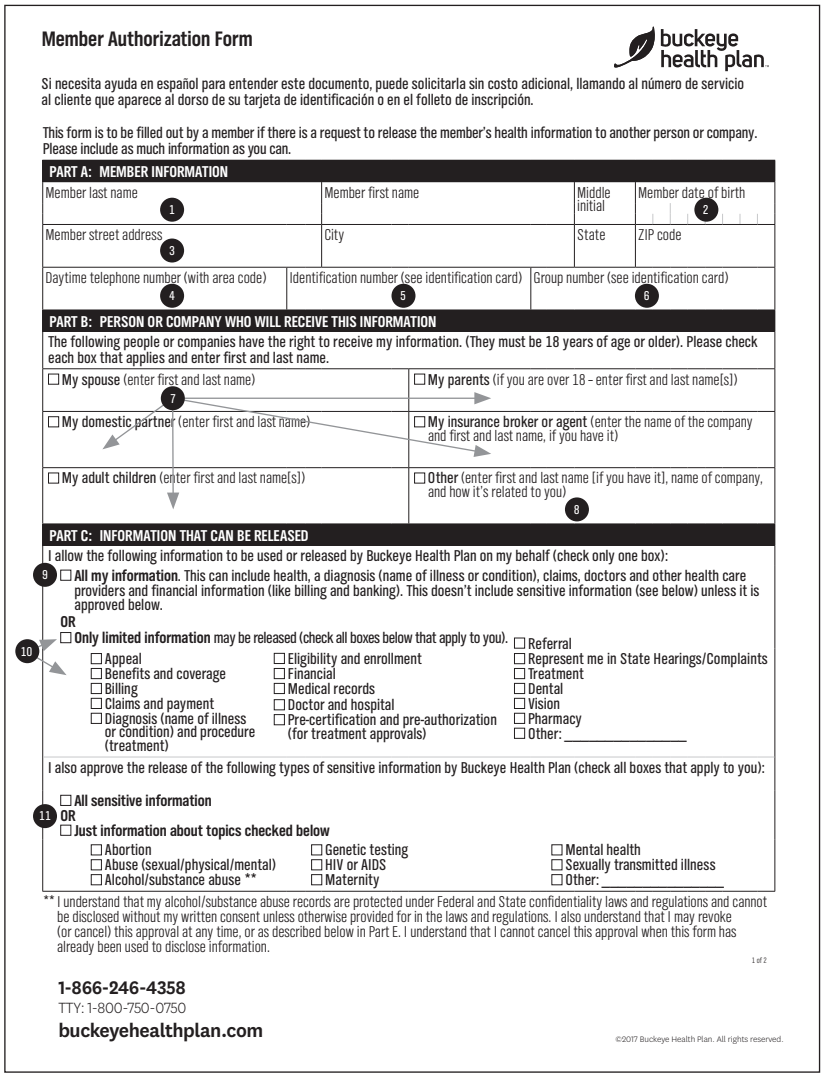
PART B: PERSON OR COMPANY WHO WILL RECEIVE THIS INFORMATION

7. 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.
8. 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.

9. For "all of your information," check the first box.
10. For "limited information," check the second box and the boxes that apply to you.
11. 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.



Member Authorization Form

buckeye health plan

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 (1)	Member first name	Middle initial	Member date of birth (2)
Member street address (3)	City	State	ZIP code
Daytime telephone number (with area code) (4)	Identification number (see identification card) (5)	Group number (see identification card) (6)	

PART B: PERSON OR COMPANY WHO WILL RECEIVE THIS INFORMATION

The following people or companies have the right to receive my information. (They must be 18 years of age or older). Please check each box that applies and enter first and last name.

(7)

- ☐ **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) (8)

PART C: INFORMATION THAT CAN BE RELEASED

I allow the following information to be used or released by Buckeye Health Plan on my behalf (check only one box):

(9) ☐ **All my information**. This can include health, a diagnosis (name of illness or condition), claims, doctors and other health care providers and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below.

OR

(10) ☐ **Only limited information** may be released (check all boxes below that apply to you).

- ☐ Appeal
- ☐ Benefits and coverage
- ☐ Billing
- ☐ Claims and payment
- ☐ Diagnosis (name of illness or condition) and procedure (treatment)
- ☐ Eligibility and enrollment
- ☐ Financial
- ☐ Medical records
- ☐ Doctor and hospital
- ☐ Pre-certification and pre-authorization (for treatment approvals)
- ☐ Referral
- ☐ Represent me in State Hearings/Complaints
- ☐ Treatment
- ☐ Dental
- ☐ Vision
- ☐ Pharmacy
- ☐ Other: _____

I also approve the release of the following types of sensitive information by Buckeye Health Plan (check all boxes that apply to you):

(11) ☐ **All sensitive information**

OR

☐ **Just information about topics checked below**

- ☐ Abortion
- ☐ Abuse (sexual/physical/mental)
- ☐ Alcohol/substance abuse **
- ☐ Genetic testing
- ☐ HIV or AIDS
- ☐ Maternity
- ☐ Mental health
- ☐ Sexually transmitted illness
- ☐ Other: _____

** 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.

1 of 2

1-866-246-4358
TTY: 1-800-750-0750
buckeyehealthplan.com

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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.

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

PART E: DATE YOUR APPROVAL EXPIRES

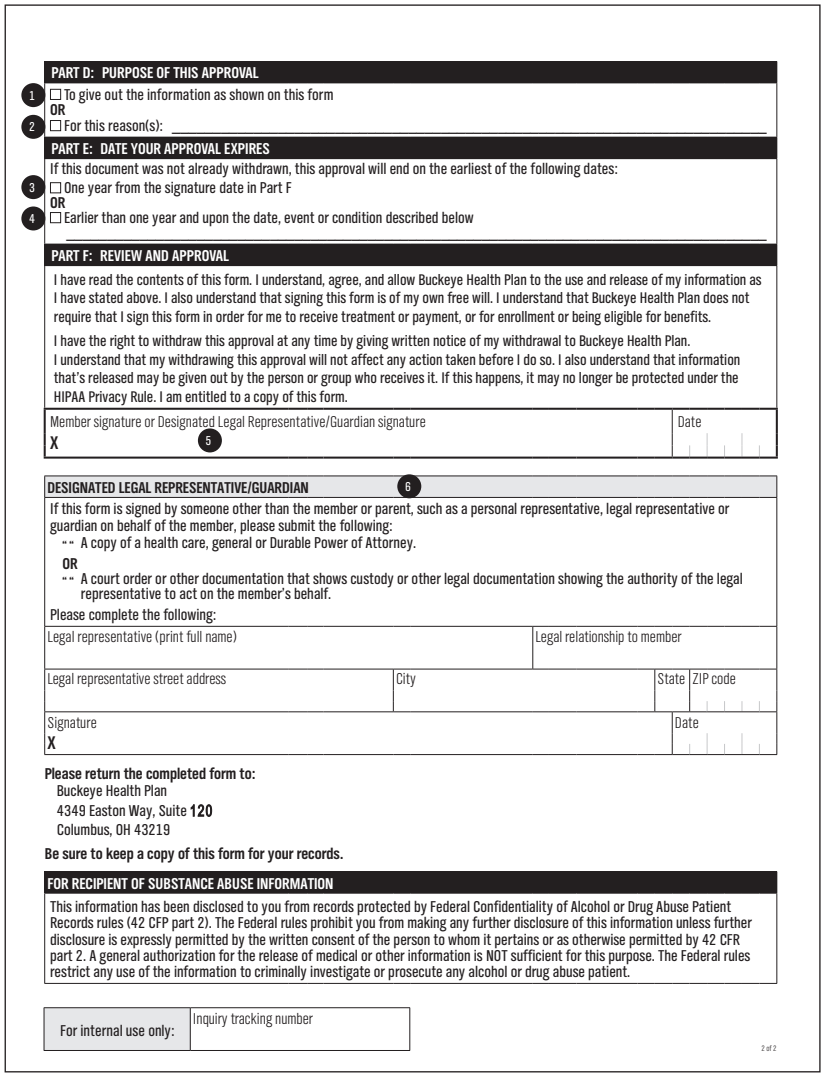
You have two choices of when you would like this approval to end.

3. Check the first box for the standard one-year that it will end.
4. 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

5. **Sign your name and put the date on the form.** Your name and signature ***must*** match the information in Part A.
6. **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.



PART D: PURPOSE OF THIS APPROVAL

1 ☐ To give out the information as shown on this form
OR
2 ☐ For this reason(s): _____

PART E: DATE YOUR APPROVAL EXPIRES

If this document was not already withdrawn, this approval will end on the earliest of the following dates:
3 ☐ One year from the signature date in Part F
OR
4 ☐ Earlier than one year and upon the date, event or condition described below
_____

PART F: REVIEW AND APPROVAL

I have read the contents of this form. I understand, agree, and allow Buckeye Health Plan to the use and release of my information as I have stated above. I also understand that signing this form is of my own free will. I understand that Buckeye Health Plan does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to Buckeye Health Plan. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Member signature or Designated Legal Representative/Guardian signature 5 | Date
X

DESIGNATED LEGAL REPRESENTATIVE/GUARDIAN 6

If this form is signed by someone other than the member or parent, such as a personal representative, legal representative or guardian on behalf of the member, please submit the following:
- A copy of a health care, general or Durable Power of Attorney.

OR
- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.

Please complete the following:

Legal representative (print full name) | Legal relationship to member

Legal representative street address | City | State | 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

2 of 2

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.

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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

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Daytime telephone number (with area code)	Identification number (see identification card)	Group number (see identification card)

PART B: PERSON OR COMPANY WHO WILL RECEIVE THIS INFORMATION

The following people or companies have the right to receive my information. (They must be 18 years of age or older). Please check each box that applies and enter first and last name.

☐ 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 RELEASED

I allow the following information to be used or released by Buckeye Health Plan on my behalf (check only one box):

☐ **All my information**. This can include health, a diagnosis (name of illness or condition), claims, doctors and other health care providers and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below.

OR

☐ **Only limited information** may be released (check all boxes below that apply to you).

- ☐ Appeal
- ☐ Benefits and coverage
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- ☐ Vision
- ☐ Pharmacy
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1-866-246-4358
TTY: 1-800-750-0750
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PART D: PURPOSE OF THIS APPROVAL

☐ To give out the information as shown on this form
OR
☐ For this reason(s): _____

PART E: DATE YOUR APPROVAL EXPIRES

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I have the right to withdraw this approval at any time by giving written notice of my withdrawal to Buckeye Health Plan.

I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

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 parent, such as a personal representative, legal representative or guardian on behalf of the member, please submit the following:

- A copy of a health care, general or Durable Power of Attorney.

OR

- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.

Please complete the following:

Legal representative (print full name)	Legal relationship to member

Legal representative street address	City	State	ZIP code

Signature	Date
X	

Please return the completed form to:
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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*.

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: तपाईं 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 1-866-246-4358 (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 (TTY: 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 (TTY: 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: که تاسو انګلیسي خبرې کوئ، د ژبې مرستې خدمتونه، وړیا، تاسو لپاره شتون لري.
1-866-549-8289 (TTY: 711)
ته زنګ ووهئ.

Amharic:
ትኩረት፦ አማርኛ የሚናገሩ ከሆነ፣ ለእርስዎ የሚሆኑ ከክፍያ ነጻ የቋንቋ እገዛ አገልግሎቶች አሉን። በ 1-866-246-4358 (TTY: 711) ይደውሉ።

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