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.

	ber Authorization Form					ال	buckeye health pla	an.
	sita ayuda en español para entende te que aparece al dorso de su tarjet					al, llamando a	Il número de servicio	
	rm is to be filled out by a member if t include as much information as you o		request to releas	se the member's hea	lth inforn	nation to anot	her person or compan	ıy.
PART	A: MEMBER INFORMATION							
Membe	er last name		Member first name			Middle initial	Member date of birth	
Membe	er street address		City		St		ZIP code	
Daytim	rtime telephone number (with area code) Identification number (d) Group	number (see i	identification card)	
DART	B: PERSON OR COMPANY WHO WIL	I RECEIV	E THIS INFORMA	ATION				
The fo	ollowing people or companies have t box that applies and enter first and	he right 1	to receive my in		st be 18	years of age	or older). Please ched	ck
□Му	spouse (enter first and last name)			☐ My parents (if y	ou are ove	er 18 - enter fi	rst and last name(s))	
□Му	domestic partner (enter first and las	t 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 REL	EASED				8		
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1-866-246-4356

TTY: 1-800-750-0750



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.

PART D: PURPOSE OF THE		1			
OR For this reason(s):					
PART E: DATE YOUR APPI	ROVAL EXPIRES				
		proval will end on the earli	est of the following da	tes:	
□ One year from the sign: OR	ature date in Part F				
☐ Earlier than one year ar	nd upon the date, event or	condition described below			
PART F: REVIEW AND API	PROVAL				
I have stated above. I also	understand that signing t	agree, and allow Buckeye H this form is of my own free v ve treatment or payment, or	will. I understand that B	Buckeye Health I	Plan does not
I understand that my with that's released may be gi	drawing this approval will	e by giving written notice on not affect any action taken roup who receives it. If this orm.	n before I do so. I also u	nderstand that	information
Mombor cianaturo or Docise	nated Legal Representative/	Guardian signature			Date
menner alknarme or neally	X 5				
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DESIGNATED LEGAL REPRE If this form is signed by so guardian on behalf of the A copy of a health c	SENTATIVE/GUARDIAN omeone other than the me		personal representative	e, legal represei	ntative or
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X DESIGNATED LEGAL REPRE If this form is signed by siguardian on behalf of the " A copy of a health corn OR A court order or oth representative to at Please complete the follor Legal representative (print of the corn X Please return the complete Buckeye Health Plan 4349 Easton Way, Suite Columbus, OH 43219 Be sure to keep a copy of FOR RECIPIENT OF SUBSTA This information has been	SENTATIVE/GUARDIAN menone other than the me member, please submit th are, general or Durable Pov er documentation that sh ct on the member's behalf, wing: "ull name) address ted form to: 400 this form for your record INCE ABUSE INFORMATION disclosed to you from rec	mber or parent, such as a perfollowing: wer of Attorney. ows custody or other legal City City	documentation showing Legal relation	g the authority mship to member Stat	e ZIP code ate

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.

1-866-246-4356

TTY: 1-800-750-0750

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)	fication number (see identification card) Group n		number (see identification card)				
PART B: PERSON OR COMPANY WHO WILL F	RECEIV	E THIS INFORMA	ATION				
The following people or companies have the right each box that applies and enter first and last na	nt to re ime.	eceive my informa	ntion. (They must be 18 y	ears of a	age or older	r). 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 na	ame)		☐ 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 released by Buckeye Health Plan on my behalf (check only one box):							
All my information. This can include heal providers and financial information (like bil approved below.	th, a d Iling aı	iagnosis (name of nd banking). This (f illness or condition), cla doesn't include sensitive	nims, doc informa	tors and ot tion (see be	her health care elow) unless it is	
OR □ Only limited information may be release	ed (che	eck all hoxes helov	w that annly to you)	□ Dofou	اما		
Appeal Eligibility and enrolln Benefits and coverage Financial Billing Medical records Claims and payment Doctor and hospital Diagnosis (name of illness Pre-certification and or condition) and procedure (for treatment appro			ent [[[[pre-authorization [□ Treatn □ Dental □ Vision □ Pharm	sent me in S nent	State Hearings/Complaints	
I also approve the release of the following types	of sei	nsitive informatio	n by Buckeye Health Plar	n (check	all boxes th	at apply to you):	
☐ All sensitive information OR							
☐ Just information about topics checked	d belo	W					
☐ Abortion ☐ Genetic testing ☐ HIV or AIDS ☐ Maternity				\square S	lental healt exually tran ther:	h smitted illness	

** 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

1-866-246-4356

TTY: 1-800-750-0750

DADT D. DUDDOSE OF THIS ADDDOVAL						
PART D: PURPOSE OF THIS APPROVAL						
\square To give out the information as shown on this form ${f OR}$						
☐ 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:				
One year from the signature date in Part F						
OR □ 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 o	f my information as			
I have stated above. I also understand that signing this form is						
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						
that's released may be given out by the person or group who re	eceives it. If this happens,	it may no longer be prote	cted under the			
HIPAA Privacy Rule. I am entitled to a copy of this form.	1		,			
Member signature or Designated Legal Representative/Guardian sig	Date					
X						
DESIGNATED LEGAL REPRESENTATIVE/GUARDIAN						
If this form is signed by someone other than the member or pa		presentative, legal repres	sentative or			
guardian on behalf of the member, please submit the following						
 A copy of a health care, general or Durable Power of Attornal 	rney.					
ORA court order or other documentation that shows custody	, or other legal documents	ation showing the authori	ty of the legal			
representative to act on the member's behalf.	or other logar accuments	and distribution	cy or the logar			
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 Éaston Way, Suite 400						
Columbus OH /13210						

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:	king 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, or sex.

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, or sex, you can file a grievance with: Buckeye Health Plan at the Appeals Unit, 4339 Easton Way, Suite 400, 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 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).

Chinese Mandarin:

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 1-866-246-4358 (TTY: 711)。

German:

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-246-4358 (TTY: 711).

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم -1 ,668-642-8534 (رقم هاتف الصم والبكم: 711).

Pennsylvania Dutch:

Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-866-246-4358 (TTY: 711).

Russian:

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-246-4358 1-866-549-8289 (телетайп: 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:

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

Cushite:

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-866-246-4358 (TTY: 711).

Korean:

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-246-4358 (TTY: 711) 번으로 전화해 주십시오.

Italian:

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-246-4358 (TTY: 711).

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。1-866-246-4358 (TTY: 711)まで、お電話にてご連絡ください。

Dutch:

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-866-246-4358 (TTY: 711).

Ukraninian:

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-866-246-4358 (телетайп: 711).

Romanian:

ATENŢIE: Dacă vorbiţi limba română, vă stau la dispoziţie servicii de asistenţă lingvistică, gratuit. Sunaţi la 1-866-246-4358 (TTY: 711).

Somali:

LA SOCO: Haddii aad ku hadasho Ingiriisi, adeegyada taageerada luqada, oo bilaash ah, ayaad heli kartaa, Wac 1-866-246-4358 (TTY: 711).

Nepali:

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-866-246-4358 (टिटिवाइ: 711) ।