Instructions for completing the Member Authorization Form



AmeriBen

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.

Member Authorization 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: mmddyyyy. (If you were born on October 5, 1960, you would write 10051960.)
- 3 Write your full street address, city, state, and ZIP code.
- Write your daytime phone number (including area code.)
- 6 Write your cell/mobile number (including area code.)

6 Identification number

You will find this number on your member identification card.

Oroup 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

- 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.

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Part A: Member informa	ation						
Aember last name		Member first n	Member first name		ddle tial	Member date of birth (MMDDYYYY)	
Member street address		City		Sta	State ZIP code Group number (see identification card)		
Daytime telephone number (with area code)	Cell/mobile te (with area cod	lephone number je) 5	Identification number (see identification card)				
Part B: Person or compa	ny who will receive t	this information					
The following people or c	ompanies have the rig	ght to receive my i	nformation. (They must be 10 n may receive my informatio		s of age	or older). Please ent	
My spouse (enter first and			My parents (if you are over				
My domestic partner (ent	er first and last name)		My insurance broker or ag and first and last name, if yo	ent (en ou have	iter the i it)	name of the company	
My adult children (enter f	irst and last name[s])		Other (enter first and last n and how it's related to you)	ame (if	you hav	e it], name of company	
Part C: Information that	can be released			-			
All my information. providers and financi it is approved below.	This can include healt ial information (like b	th a diagnosis (nar	len on my behalf: Check only ne of illness or condition), cli . This doesn't include sensiti	h amir	octors :	and other health care (see below) unless	
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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.

- 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.

- Oheck 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 this a To give out the informa	tion as shown on this form.					
OR						
□ For this reason(s):						
	al expires – Check only one box.					
If this document was not a One year from the signal	already withdrawn, this approval wil	l end on the earliest	of the following dat	es:		
OR	alure uale in Farl F.					
\Box Earlier than one year ar	nd upon the date, event or condition	described below:				
Part F: Review and appro	val of this form. I understand, agree, and	l allour AmariDan ta t	he use and veloces a	f mu infor	mation	an I have
stated above or as require A meriBen does not require for benefits. I have the right to withdra withdrawing this approval	ed by applicable law. I also understa that I sign this form in order for me w this approval at any time by givin will not affect any action taken bei	nd that signing this to receive treatmer g written notice of m ore I do so. I also un	form is of my own fre at or payment, or for ay withdrawal to A me derstand that inform	ee will. I ur enrollmen riBen I und nation that	idersta t or be erstan t's rele	and that eing eligible nd that my eased may be
entitled to a copy of this f	r group who receives it. If this happe form.	ins, it may no longer	ne hlorecrea aurel	UIE HIPAA	Privau	y Rule. I alli
Member signature or Design	ated Legal Representative/Guardian s	ignature		Da	te (MM	DDYYYY)
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If this form is signed by so	y if you have documentation supp omeone other than the member or p	arent, such as a per		e, legal rep	resen	tative or
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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.

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

Nember last name		Member first name			iddle itial	Member date of birth (MMDDYYYY)		
Member street address		City		St	tate	ZIP code		
Daytime telephone number (with area code) (with area code)					Group number (see identification card)			
Part B: Person or company who	will receive this	information						
The following people or companie first and last name. By entering f	es have the right t Tirst/last name be	to receive my inf low that person	ormation. (They must be may receive my informat	18 years ion.	s of age	or older). Please enter		
My spouse (enter first and last nar		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		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 All my information. This car providers and financial inforit is approved below. OR Only limited information mails and coverage Benefits and coverage Billing Claims and payment Doctor and hospital Diagnosis (name of illm 	include health, a mation (like billing ay be released (ch ess or condition)	diagnosis (name g and banking). T leck all boxes be Eligibility and e Financial Medical records Pre-certification (for treatment a and procedure (e of illness or condition), o This doesn't include sensi low that apply to you). nrollment s n and pre-authorization approvals) treatment):	claims, d tive info Refe Trea Dent Visio Phar	doctors a ormation erral ttment tal on rmacy	(see below) unless		
I also approve the release of the following types of sensitive information by AmeriBen (check all boxes that apply to you): All sensitive information ² OR Just sensitive information about topics checked below								
□ Abuse (sexual/physica□ Substance use disorde□ Genetic testing	r ^{1,2}	HIV or AIDS Mental health Sexually transm		(incl	roductive luding ab	e health ³ ortion, maternity, etc.)		
 Specify time period of records to be disclosed:								

AmeriBen is a separate and independent company providing medical benefit plan administration services on behalf of self-funded group health plans.

Part D: Purpose of this approval – Check only one box.

□ To give out the information as shown on this form.

OR

 \Box For this reason(s):

Part E: Date your approval expires - Check only one box.

If this document was not already withdrawn, this approval will end on the earliest of the following dates: \Box One year from the signature date in Part F.

OR

 \Box 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 AmeriBen to the use and release of my information as I have stated above or as required by applicable law. I also understand that signing this form is of my own free will. I understand that AmeriBen 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 AmeriBen. 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 (MMDDYYYY)				
X							

Designated Legal Representative/Guardian -

Complete this section only if you have documentation supporting Legal Representation.

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 X		Da	ite (MN	IDDYYYY)	

Please return the completed form to:

AmeriBen

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

AmeriBen is a separate and independent company providing medical benefit plan administration services on behalf of self-funded group health plans.

 For internal use only:
 Inquiry tracking number