Louisiana

BlueCross BlueShield Federal Employee Program.

Do you want us to share your health information with someone?

Fill Out the Form to Name an Authorized Delegate

For Federal Employee Program

What Is the Purpose of This Form?

Fill out this form to allow Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc. (collectively called Blue Cross) to share information about your healthcare account with someone else. For instance, you might want us to share your private healthcare information with your spouse, another family member, your child's guardian, your insurance agent, or your employer.

If you fill out and sign this form, we will share your claims or benefit information with anyone you choose. We call the person or organization you choose your *authorized delegate*.

Anyone you name as an authorized delegate will only receive information. They will not be allowed to change anything about your policy unless you also give them the power of attorney.

If you do not fill out this form, we will still continue serving you. We will just not be able to share your information.

Once you send us your completed form, we will share your claims and benefit information with your authorized delegate for as long as you allow us to do so.

Your authorization will be valid as long as you have your health insurance with us. If you cancel your insurance, your authorization will end.

If this authorization covers a minor child, it will end on that child's 18th birthday.

Still have questions?

Call us. We will be happy to help you.

Call Customer Service at: 1-800-272-3029

Should You Use This Form?

You should use this form if:

- you are 18 years old or older, or
- your healthcare policy covers a minor child and you want to share that child's information with someone else, or
- you are a member's legal representative and you want to share that member's information with someone else. If you are a legal representative, along with this form, you must send us copies of the documents that prove your legal status.

You must fill out the form. Verbal approval is temporary.

If you have called us to name an authorized delegate and have received temporary approval from us, you must fill out and sign this form so that your authorized delegate can continue to receive information from us. Your verbal approval is only valid for 2 weeks (14 calendar days) after we talk to you.

Can You Change Your Decision?

Yes, you may change your decision about sharing your information at any time. If you decide that you no longer want us to share your information with an authorized delegate, write to us.

Withdrawing your permission will not affect any action we take before we receive your letter. In your letter, include a copy of your driver's license so that we can verify your identity.

Fax us at: (225) 298-1590

Call us at: (225) 298-1751

Write to us at: Privacy Office
Blue Cross and Blue Shield of Louisiana
P.O. Box 98029
Baton Rouge, LA 70898-9029

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and is incorporated as Louisiana Health Service & Indemnity Company. Blue Cross and Blue Shield Plans are independent licensees of the Blue Cross and Blue Shield Association.

Name an Authorized Delegate

Fill out this form to allow us to share information about your healthcare account with someone else.
If this form is not filled out, we will still continue serving you. We will just not be able to share your information.

Part 1: Tell Us About Yourself

If you are a member and you want us to share your health information with an authorized delegate, fill out Part 1 about yourself.

If you are a legal representative of a member and you want us to share that member's information with someone, fill out Part 1 with the member's information.

Name of member whose information we will share Fill in the member's name as it appears on the member ID card					
Mailing address	Street				
	City		State		ZIP code
Member ID number as shown on the ID card		OR	Social security number	__ __ __ - __ __ - __ __ __ __	

Part 2: Tell Us About Your Authorized Delegate

We understand that you want to name the following person or organization as your authorized delegate. *Note*: If the people or organizations you name are not required to follow the federal health information privacy laws, they may share your information with someone else and federal privacy laws may no longer protect your information.

You may change your decision at any time. Withdrawing your permission will not affect any action we take before then. If you no longer want us to share your information with an authorized delegate, write to us. In your letter, include a copy of your driver's license so that we can verify your identity.

To name a	If your authorized delegate is a person, fill out this section.	Person's name				
		Mailing address	Street			
			City		State	ZIP code
		Date of birth	____/____/_____ MM / DD / YYYY	OR	Driver's license number:	
To name another person	If your authorized delegate is a person, fill out this section.	Person's name				
		Mailing address	Street			
			City		State	ZIP code
		Date of birth	____/____/_____ MM / DD / YYYY	OR	Driver's license number:	
To name an organization	If your authorized delegate is an organization, fill out this section.	Organization name				
		Mailing address	Street			
			City		State	ZIP code
		Employer Identification Number (EIN)	__ __ - __ __ __ __ __ __ __			

Part 3: Sign Here if You Are the Member

I give Blue Cross permission to share any of my personal information that is protected by federal or state law with the authorized delegates named in Part 2 of this form. I understand that this personal information may have detailed medical information about me, including information about alcohol or drug use and mental health conditions. That information does not include psychotherapy notes, HIV information, or genetic information. (If I want to share that type of information, I will fill out a different form called the *Authorization for the Use/Release of Protected Health Information*. I will call Customer Service for a copy.)

This authorization will be valid until I tell Blue Cross to no longer share my information or until my health insurance with Blue Cross is ended.

My signature	X	Today's date	_____/____/_____ MM / DD / YYYY

Part 4: Sign Here if You Are the Legal Representative for the Member

To show that you are legally designated as the member's representative, when you send us this form you must also send us copies of any legal documents that prove you have guardianship or power of attorney.

I am authorized as a personal representative for the member who is named in Part 1 of this form. I am legally designated as a parent of a minor, legal guardian, or holder of power of attorney.

I understand that this authorization will be valid as long as the member's health insurance with Blue Cross is in effect. If the insurance is canceled, the authorization will end.

If this authorization covers a minor child, it will end on that child's 18th birthday.

My signature	X	Today's date	_____/____/_____ MM / DD / YYYY
My relationship to the member			

After you fill out the form, send it to us.

Fax it to us at: (225) 295-2364

Mail it to us at:
FEP Customer Service
Blue Cross and Blue Shield of Louisiana
P.O. Box 98028
Baton Rouge, LA 70898-9028

Or
Email it to us at: **help@**bcbsla.com

This email address is not secure. There is a small risk that others could see your message.

To keep your information the most private, use our secure online inquiry form at bcbsla.com/ContactUs.

Still have questions?

Call us. We will be happy to help you.

Call Customer Service at: 1-800-272-3029

BlueCross BlueShield
Federal Employee Program

fepblue.org

NONDISCRIMINATION NOTICE

The Blue Cross and Blue Shield Service Benefit Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Blue Cross and Blue Shield Service Benefit 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 the Civil Rights Coordinator of your local Blue Cross and Blue Shield company by calling the customer service number on the back of your member ID card.

If you believe that this 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 the Civil Rights Coordinator of your local BCBS company. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, your local BCBS company's 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 Avenue, SW
Room 509F, HHH Building
Washington, D.C. 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

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Gọi số dịch vụ khách hàng trên thẻ ID của quý vị để được hỗ trợ bằng Tiếng Việt.

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

اتصل برقم خدمة العملاء الموجود على بطاقة هُويتك للحصول على المساعدة باللغة العربية.

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Pour une assistance en français du Canada, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

Ligue para o número de telefone de atendimento ao cliente exibido no seu cartão de identificação para obter ajuda em português.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

日本語でのサポートは、IDカードに記載のカスタマーサービス番号までお電話でお問い合わせください。

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

Rufen Sie den Kundendienst unter der Nummer auf Ihrer ID-Karte an, um Hilfestellung in deutscher Sprache zu erhalten.

برای دریافت راهنمایی به زبان فارسی ، با شماره خدمات مشتری که بر روی کارت شناسایی شما درج شده است تماس بگیرید..