Instructions for Completing Confidential Information Release Form

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

Please fill out this form if you would like Blue Cross Blue Shield of Arizona (BCBSAZ) to share your information with the person or company you mention on the form. Each member who is 18 or older has to fill out and sign a separate form.

Why Might You Want BCBSAZ to Share Your Records?

BCBSAZ has to keep your information private. BCBSAZ needs this form if you want us to share your records with:

- Your spouse, parent or child so they can discuss claims questions with BCBSAZ.
- Your broker, after you sign up for a health plan so he/she can help with claims.
- Your lawyer for an injury case.

How to Fill Out This Form

Tell Us What Records We Can Share: Tell us what you want us to share. Check at least one box.

Tell Us Whose Records We Can Share: Write the name of the BCBSAZ member this form is for. This is usually your name.

Tell Us Who Can Get the Records: Tell us who can get the information. This might be the name of a person, or it could be the name of a business, like a medical group if you don't want us to send the records to a specific person.

Tell Us Why You Want Us To Share Your Records: Tell us why you want us to share your information. Check at least one box. If you don't have a special reason, please check "Other reason" and write in "At My Request."

Change My Records: Tell us if the person can change your address or bank account information. Note: This part of the form is optional.

Tell Us When to Stop Sharing Your Information: Tell us when you want us to stop sharing your records. You must check at least one box. If you check the box by "The date marked here," please write the date we should stop sharing. If you don't have a specific date, check the 90-day box. No matter what box you check, if you change your mind, you can also ask us to stop any time. Write to our Privacy Office.

BCBSAZ Member's ID Number: Enter the BCBSAZ ID number of the person whose records will be shared. If you do not know the ID number, use the Social Security number.

Signature: Print and sign your name and date the form.

Group Name and Number: If you have coverage through your work, you are in a group plan. Enter the name and number of your group health plan if this applies.

Representative's Name/Signature: If you are signing the form because you are acting for someone else, fill in your name, sign and date the form. Include a copy of the legal papers that apply.

Questions?

For questions about the form, please call **602-864-2255 or 800-232-2345** extension **2255.**

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Use this form to let a person or firm get your information, except HIV information. We have a different form for HIV information. You can also use this form to let them change your address or bank information. Even if you don't sign this form, Blue Cross Blue Shield of Arizona (BCBSAZ) will still pay your claims, sign you up for our plan and let you be eligible for benefits. This form is not required.

Tell Us What Records We Can Share: BCBSAZ can give out what is marked below. Some of these records may have details about contagious diseases, alcohol and drug abuse treatment and genetic testing: (Check all that apply.)

- ☐ Application, Enrollment, Eligibility Information
- ☐ Billing/Payment Information
- ☐ Claims/Explanation of Benefits Information
- ☐ Medical or Dental Records, Procedure & Diagnosis Codes
- ☐ Precertification Information
- ☐ Account Information
- ☐ Other (please explain) _____

Tell Us Whose Records We Can Share:

Tell Us Who Can Get the Records:

Name	Company Name		
Address	City	State	Zip Code

Note: If you tell us to share with someone, the person who gets your records may not keep them private. Your records won't be protected anymore under federal privacy laws.

Tell us Why You Want Us to Share Your Records: (Check all that apply)

- ☐ To help get a health care policy
- ☐ To help with claims or payments
- ☐ Other reason (Please explain):

Change My Records:

I also want to let (name):

- ☐ Change My Address
- ☐ Update My Bank Information

Tell Us When to Stop Sharing Your Information:

- ☐ 90 days after the health plan ends
- ☐ The date marked here:

You may tell us to stop sharing your records at any time. **If you want us to stop sharing, write to us at: BCBSAZ Privacy Office, Mail Stop C302, P. O. Box 13466, Phoenix, AZ 85002-3466. If you tell us to stop sharing, it will not change what BCBSAZ shared before you told us to stop.**

Your Name	BCBSAZ Member's Identification Number
Your Signature	Date Signed (MM/DD/YYYY)
Group Name (if this applies)	Group Number (if this applies)
Representative's Name*	Relationship to BCBSAZ Member
Representative's Signature	Date Signed (MM/DD/YYYY)

* If you are asking us to share records for someone other than yourself, please tell us why you can do this. Also, attach a copy of any legal paper(s) that apply.

You can get a copy of this form after you sign it. You may refuse to sign this form.

Please send us the filled out form.

Mail it to: **BCBSAZ, Attention: Enrollment, P.O. Box 13466, Phoenix AZ 85002-3466**
Fax it to: **602-864-4041**

Multi-language Interpreter Services

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross Blue Shield of Arizona, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 602-864-4884.

Navajo: Díí kwe'é atah nílínigíí Blue Cross Blue Shield of Arizona haada yit'éego bína'ídíłkidgo éí doodago Háida bíjá anilyeedígíí t'áadoo le'é yína'ídíłkidgo beehaz'áanii hóló̜ díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'á̜ doo bá̜á̜h ílínígóó. Ata' halne'ígíí kojí̜' bich'į' hodíilnih 877-475-4799.

Chinese: 如果您，或是您正在協助的對象，有關於插入項目的名稱 Blue Cross Blue Shield of Arizona 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 在此插入數字 877-475-4799。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross Blue Shield of Arizona quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 877-475-4799.

Arabic:

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Blue Cross Blue Shield of Arizona، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة .للتحدث مع مترجم اتصل ب 877-475-4799.

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue Cross Blue Shield of Arizona, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 877-475-4799.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Blue Cross Blue Shield of Arizona 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 877-475-4799 로 전화하십시오.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue Cross Blue Shield of Arizona, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 877-475-4799.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue Cross Blue Shield of Arizona haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 877-475-4799 an.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue Cross Blue Shield of Arizona, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 877-475-4799.

Japanese: ご本人様、またはお客様の身の回りの方でも、Blue Cross Blue Shield of Arizona についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、877-475-4799 までお電話ください。

Farsi:

اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Blue Cross Blue Shield of Arizona ، داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید 877-475-4799
.تماس حاصل نمایید

Assyrian:

ܐܢ ܐܢܬ، ܝܢ ܚܕ ܐܢܫܐ ܕܩܐ ܡܥܕܪܢܬܘܟ، ܐܝܬ ܠܘܟ ܒܘܩܪܐ ܥܠ Blue Cross Blue Shield of Arizona، ܐܝܬ ܠܘܟ ܙܕܩܐ ܕܡܩܒܠܬ ܥܘܕܪܢܐ ܘܡܘܕܥܢܘܬܐ ܒܠܫܢܘܟ ܡܓܢܐܝܬ. ܠܡܡܠܠܐ ܥܡ ܚܕ ܡܬܪܓܡܢܐ، ܩܪܝ ܠ ܡܢܝܢܐ 877-475-4799.

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue Cross Blue Shield of Arizona, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 877-475-4799.

Thai: หากคุณ หรือคนที่คุณกาลังช่วยเหลือมีคำถามเกี่ยวกับ Blue Cross Blue Shield of Arizona คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 877-475-4799

Blue Cross Blue Shield of Arizona (BCBSAZ) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BCBSAZ provides appropriate free aids and services, such as qualified interpreters and written information in other formats, to people with disabilities to communicate effectively with us. BCBSAZ also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call 602-864-4884 for Spanish and 1-877-475-4799 for all other languages and other aids and services.

If you believe that BCBSAZ 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: BCBSAZ's Civil Rights Coordinator, Attn: Civil Rights Coordinator, Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466, 602-864-2288, TTY/TDD 602-864-4823, crc@azblue.com. You can file a grievance in person or by mail or email. If you need help filing a grievance BCBSAZ'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, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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