Blue Cross and Blue Shield of Minnesota and Blue Plus

Processing Center
P.O. Box 982819
El Paso, TX 79998-2819

BlueCross BlueShield Minnesota

We need your OK before we can give out your records to others or allow others to act on your behalf in filing an appeal or grievance.

Dear Member:

To ensure your privacy, we need you to fill out the form included with this letter. Once you complete the form, please send it back to us.

1. Please fill out and sign this form.

2. This form will let us know who you are allowing to view your records or file an appeal or grievance on your behalf.

3. The form is good for one year from the date you sign it, unless you ask for it to end sooner.

4. Please be sure to fill out the whole form and keep a copy for your records.

5. Please don't change the form or leave things out. If we have questions or there are problems with the form, we'll send you a letter or call you.

6. If you have other forms of authorization such as Power of Attorney, you may use that document in place of this form.

We will quickly process your form once we receive it. If you have any questions, call the Member Services number on your ID card and ask to speak to the Member Privacy Unit.

Sincerely,

Member Privacy Unit
Blue Plus

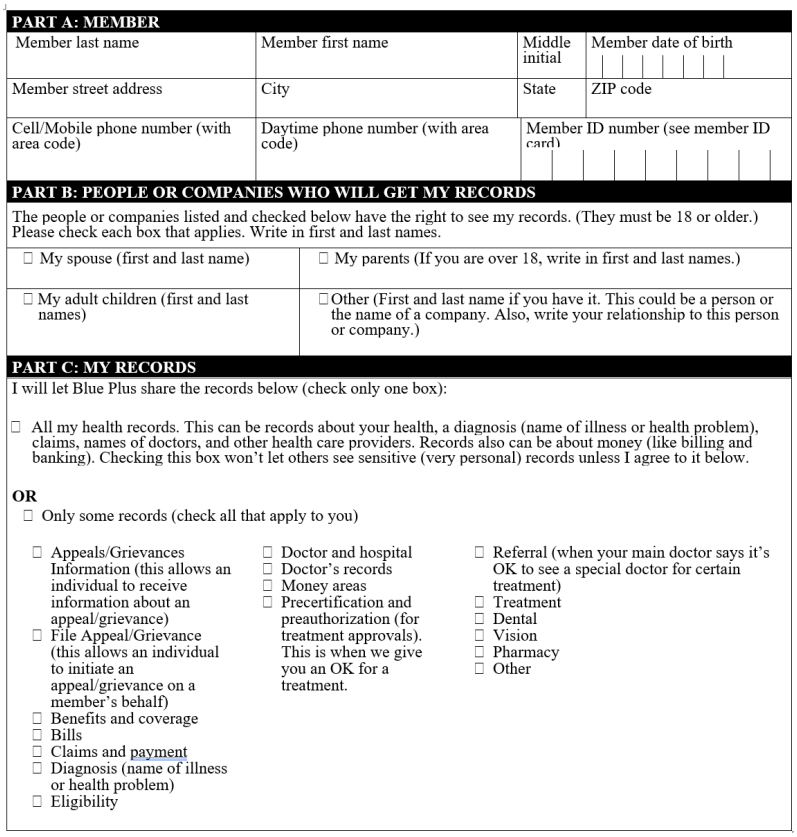
Enclosures: Member Authorization Form
[Language block]
[Complaint block]

DHS_121222_O01 DHS Approved 12/12/2022
M09096 (07/24)

Please read this page for help completing page one of the forms.

PART A: Member

1. Print your last name, first name, and the first letter of your middle name.
2. Write your date of birth like this: mm/dd/yyyy. For example, if you were born on October 5, 1960, you would write 10/05/1960.
3. Write your full street address, city, state, and ZIP code.
4. Write a daytime phone number (with area code) where to reach you.
5. Write your cell/mobile phone number (with area code) where to reach you.
6. Member ID number is on your member ID card.



PART A: MEMBER

Member last name	Member first name	Middle initial	Member date of birth
Member street address	City	State	ZIP code
Cell/Mobile phone number (with area code)	Daytime phone number (with area code)	Member ID number (see member ID card)	

PART B: PEOPLE OR COMPANIES WHO WILL GET MY RECORDS

The people or companies listed and checked below have the right to see my records. (They must be 18 or older.) Please check each box that applies. Write in first and last names.

- ☐ My spouse (first and last name)
- ☐ My parents (If you are over 18, write in first and last names.)
- ☐ My adult children (first and last names)
- ☐ Other (First and last name if you have it. This could be a person or the name of a company. Also, write your relationship to this person or company.)

PART C: MY RECORDS

I will let Blue Plus share the records below (check only one box):

☐ All my health records. This can be records about your health, a diagnosis (name of illness or health problem), claims, names of doctors, and other health care providers. Records also can be about money (like billing and banking). Checking this box won't let others see sensitive (very personal) records unless I agree to it below.

OR

☐ Only some records (check all that apply to you)

- ☐ Appeals/Grievances Information (this allows an individual to receive information about an appeal/grievance)
- ☐ File Appeal/Grievance (this allows an individual to initiate an appeal/grievance on a member's behalf)
- ☐ Benefits and coverage
- ☐ Bills
- ☐ Claims and payment
- ☐ Diagnosis (name of illness or health problem)
- ☐ Eligibility
- ☐ Doctor and hospital
- ☐ Doctor's records
- ☐ Money areas
- ☐ Precertification and preauthorization (for treatment approvals). This is when we give you an OK for a treatment.
- ☐ Referral (when your main doctor says it's OK to see a special doctor for certain treatment)
- ☐ Treatment
- ☐ Dental
- ☐ Vision
- ☐ Pharmacy
- ☐ Other

PART B: People or companies who can see my records

7. After you check the box of the person or company who can see your records, tell us the full name of the person or company allowed to view your records. Please do not use a general term like "my daughter" or "my son." You need to be very clear.
8. If you check "Other person or company," please give:
   - The first and last name (if you have it).
   - The company name (if this applies to you), and explain the relationship to you.

PART C: My records

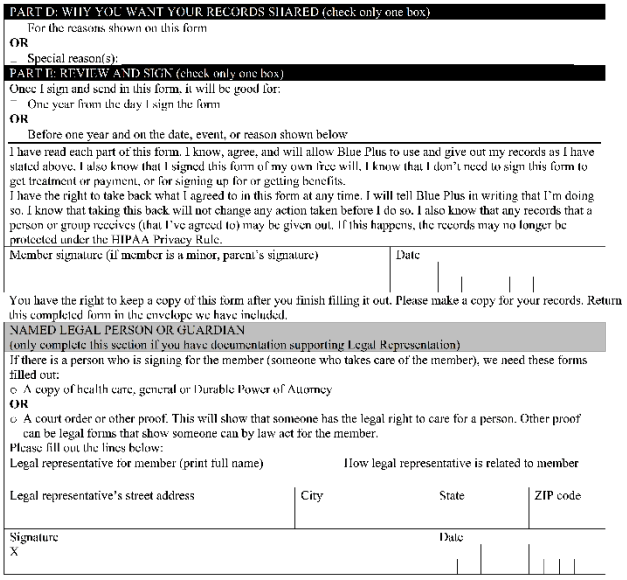
Tell us what records you will allow us to give out (all or just some):

9. To give out all of your records, check the first box.
10. To give out only some records, check the second box.
11. This section also includes records you think are very personal or very private to you. If you agree we can give out these types of records, check which boxes apply to you.

Please read this page for help completing page two of the form.

PART D: Why you want your records shared

1. The first box tells us to give out your records as shown on this form.
2. The second box tells us a special reason. This might be with a lawyer or family member. Write your reason in the space.



PART D: WHY YOU WANT YOUR RECORDS SHARED (check only one box)

For the reasons shown on this form

OR

Special reason(s):

PART E: REVIEW AND SIGN (check only one box)

Once I sign and send in this form, it will be good for:

One year from the day I sign the form

OR

Before one year and on the date, event, or reason shown below

I have read each part of this form. I know, agree, and will allow Blue Plus to use and give out my records as I have stated above. I also know that I signed this form of my own free will. I know that I don't need to sign this form to get treatment or payment, or for signing up for or getting benefits.

I have the right to take back what I agreed to in this form at any time. I will tell Blue Plus in writing that I'm doing so. I know that taking this back will not change any action taken before I do so. I also know that any records that a person or group receives (that I've agreed to) may be given out. If this happens, the records may no longer be protected under the HIPAA Privacy Rule.

Member signature (if member is a minor, parent's signature) | Date

You have the right to keep a copy of this form after you finish filling it out. Please make a copy for your records. Return this completed form in the envelope we have included.

NAMED LEGAL PERSON OR GUARDIAN

(only complete this section if you have documentation supporting Legal Representation)

If there is a person who is signing for the member (someone who takes care of the member), we need these forms filled out:

A copy of health care, general or Durable Power of Attorney

OR

A court order or other proof. This will show that someone has the legal right to care for a person. Other proof can be legal forms that show someone can by law act for the member.

Please fill out the lines below:

Legal representative for member (print full name) | How legal representative is related to member

Legal representative's street address | City | State | ZIP code

Signature | Date

X

PART E: Review and sign

Once you sign the form, it will be good for:

3. Check the first box for one year. This is the normal time.
4. Check the second box to say the form you sign will be good for less than a year. Then give the date you want it to end.
5. **Sign your name and put the date on the form.** Your name and signature *must* match what you wrote in Part A.
6. If you are signing this form for someone or if you have forms saying you have Power of Attorney for health care, or are a legal guardian or conservator, you must do this:
   - Fill in **Named Legal Person or Guardian**.
   - Give us a copy of the legal form that shows you have Power of Attorney. Include it with this form.

Here are samples of legal forms used when a person needs someone else to make choices for them.

- **Health Care, General or Durable Power of Attorney.** This form gives someone the legal power to act for you. This person can make health care choices for you. It might say this on the form: "to take charge of my person in the case of sickness of any kind." It may also say this, "and in general to do and act for me and in my name all that I might do if I am not there."
- **Legal Guardianship.** This is when the court names someone to care for a person.
- **Conservatorship.** This happens when a judge names a person to be in charge. This would be when a person can't make choices for themselves.
- **Executor of estate.** This type of form is used when the person who is being spoken for has died.

BlueCross BlueShield Minnesota

Member Authorization Form

A member must fill out this form. It allows a person or company to see the member's records or act on their behalf in filing an appeal or grievance. Please write in as much about yourself as you can. If you need help, see the letter included with this form. It will show you how to fill out each part. You can also call the Member Services number on your member ID card.

PART A: MEMBER

Member last name	Member first name	Middle initial	Member date of birth
Member street address	City	State	ZIP code
Cell/Mobile phone number (with area code)	Daytime phone number (with area code)	Member ID number (see member ID card)	

PART B: PEOPLE OR COMPANIES WHO WILL GET MY RECORDS

The people or companies listed and checked below have the right to see my records. (They must be 18 or older.) Please check each box that applies. Write in first and last names.

☐ My spouse (first and last name)	☐ My parents (If you are over 18, write in first and last names.)
☐ My adult children (first and last names)	☐ Other (First and last name if you have it. This could be a person or the name of a company. Also, write your relationship to this person or company.)

PART C: MY RECORDS

I will let Blue Plus share the records below (check only one box):

☐ All my health records. This can be records about your health, a diagnosis (name of illness or health problem), claims, names of doctors, and other health care providers. Records also can be about money (like billing and banking). Checking this box won't let others see sensitive (very personal) records unless I agree to it below.

OR

☐ Only some records (check all that apply to you)

- ☐ Appeals/Grievances Information (this allows an individual to receive information about an appeal/grievance)
- ☐ File Appeal/Grievance (this allows an individual to initiate an appeal/grievance on a member's behalf)
- ☐ Benefits and coverage
- ☐ Bills
- ☐ Claims and payment
- ☐ Diagnosis (name of illness or health problem)
- ☐ Eligibility
- ☐ Doctor and hospital
- ☐ Doctor's records
- ☐ Money areas
- ☐ Precertification and preauthorization (for treatment approvals). This is when we give you an OK for a treatment.
- ☐ Referral (when your main doctor says it's OK to see a special doctor for certain treatment)
- ☐ Treatment
- ☐ Dental
- ☐ Vision
- ☐ Pharmacy
- ☐ Other

I will also let Blue Plus share this type of sensitive (very personal) record below. Check all boxes that apply to you.

☐ All sensitive records below[2]

OR

☐ Just some records about topics checked below

- ☐ Abortion
- ☐ Abuse (sexual/physical/mental)
- ☐ Substance use disorder[1, 2] (such as alcohol and/or drug abuse treatment)
- ☐ Testing of genes
- ☐ Being pregnant
- ☐ HIV or AIDS
- ☐ Mental health
- ☐ Sexual diseases passed on to others
- ☐ Other: _____

1. Specify time period of records to be disclosed: _____

   Description of records that may be disclosed: _____

2. Unless I specify otherwise on this form, I intend this disclosure to include all substance use disorder records maintained by Blue Plus about me. I know that my substance use disorder records are protected under general and state laws and rules. This form will keep these records private. No records can be given out without my saying so in writing. This is unless it says so in the laws and rules. I also know that I may take back the fact that I agreed to this at any time as indicated below in Part E. I know that I cannot cancel this signed form after you have given out my health records.

PART D: WHY YOU WANT YOUR RECORDS SHARED (check only one box)

☐ For the reasons shown on this form

OR

☐ Special reason(s): _____

PART E: REVIEW AND SIGN (check only one box)

Once I sign and send in this form, it will be good for:

☐ One year from the day I sign the form

OR

☐ Before one year and on the date, event, or reason shown below

I have read each part of this form. I know, agree, and will allow Blue Plus to use and give out my records as I have stated above. I also know that I signed this form of my own free will. I know that I don't need to sign this form to get treatment or payment, or for signing up for or getting benefits.

I have the right to take back what I agreed to in this form at any time. I will tell Blue Plus in writing that I'm doing so. I know that taking this back will not change any action taken before I do so. I also know that any records that a person or group receives (that I've agreed to) may be given out. If this happens, the records may no longer be protected under the HIPAA Privacy Rule.

Member signature (if member is a minor, parent's signature)	Date

You have the right to keep a copy of this form after you finish filling it out. Please make a copy for your records. Return this completed form in the envelope we have included.

NAMED LEGAL PERSON OR GUARDIAN
(only complete this section if you have documentation supporting Legal Representation)

If there is a person who is signing for the member (someone who takes care of the member), we need these forms filled out:

o A copy of health care, general or Durable Power of Attorney

OR

o A court order or other proof. This will show that someone has the legal right to care for a person. Other proof can be legal forms that show someone can by law act for the member.

Please fill out the lines below:

Legal representative for member (print full name)	How legal representative is related to member

Legal representative's street address	City	State	ZIP code

Signature X	Date

Please fill out the form and mail back to:

Processing Center
PO Box 982816
El Paso, TX 79998

Blue Advantage[SM] and MinnesotaCare
Toll Free 1-800-711-9862, TTY 711

Attention. If you need free help interpreting this document, call the above number.

ያስተውሉ፡ ካለምንም ክፍያ ይህንን ዶኩመንት የሚተረጉምሎ አስተርጓሚ ከፈለጉ ከላይ ወደተጻፈው የስልክ ቁጥር ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d'une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သးဘဉ်တက့်. ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လံာ် တီလံာ်မီတခါအံၤနူဉ်,ကိးဘဉ်လီတဲစိနီၢ်ဂ်ၢ်လၢထးအံၤနူဉ်တက့်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງ ໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda (afcelinta) qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

LB2 (10-20)

Civil Rights Notice

Discrimination is against the law. Blue Plus does not discriminate on the basis of any of the following:

- Race
- Color
- National origin
- Creed
- Religion
- Sexual orientation
- Public assistance status
- Age
- Disability (including physical or mental impairment)
- Sex (including sex Stereotypes and gender identity)
- Marital status
- Political beliefs
- Medical condition
- Health status
- Receipt of health care services
- Claims experience
- Medical history
- Genetic information

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by Blue Plus. You can file a complaint and ask for help filing a complaint in person or by mail, phone, fax, or email at:
Blue Plus Privacy Unit
1800 Yankee Doodle Road, Eagan, MN 55121
Toll Free: **1-800-711-9862** TTY: **711**
Fax: **651-662-9478** Email: Civil.Rights.Coord@bluecrossmn.com

Auxiliary Aids and Services: Blue Plus provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in our health care programs. **Contact** Blue Plus at Civil.Rights.Coord@bluecrossmn.com, or call Blue Advantage[SM] and MinnesotaCare Member Services at **1-800-711-9862** (this call is free), or your preferred relay services.

Language Assistance Services: Blue Plus provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. **Contact** Blue Plus at Civil.Rights.Coord@bluecrossmn.com, or call Blue Advantage[SM] and MinnesotaCare Member Services at **1-800-711-9862** (this call is free), or your preferred relay services.

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by Blue Plus. You may also contact any of the following agencies directly to file a discrimination complaint

U.S. Department of Health and Human Services Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- Race
- Color
- National origin
- Age
- Disability
- Sex
- Religion (in some cases)

Contact the **OCR** directly to file a complaint:
Office for Civil Rights, U.S. Department of Health and Human Services
Midwest Region
233 N. Michigan Avenue, Suite 240 Chicago, IL 60601
Customer Response Center: 800-368-1019, TTY: 800-537-7697
Email: ocrmail@hhs.gov

Minnesota Department of Human Rights (MDHR)
In Minnesota, you have the right to file a complaint with the MDHR if you have been discriminated against because of any of the following:

- Race
- Color
- National origin
- Religion
- Creed
- Sex
- Sexual orientation
- Marital status
- Public assistance status
- Disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
540 Fairview Avenue North, Suite 201, St. Paul, MN 55104
651-539-1100 (voice), 800-657-3704 (toll-free), 711 or 800-627-3529 (MN Relay), 651-296-9042 (fax)
Info.MDHR@state.mn.us (email)

Minnesota Department of Human Services (DHS)
You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- Race
- Color
- National origin
- Religion (in some cases)
- Age
- Disability (including physical or mental impairment)
- Sex (including sex stereotypes and gender identity)

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. We will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have the right to appeal if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administrative actions.

Contact **DHS** directly to file a discrimination complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For elders age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.