BlueCross BlueShield of South Carolina

An Independent Licensee of the Blue Cross and Blue Shield Association

Authorized Representative Form

Section 1: Appointment of Authorized Representative

I, ______________________________ (Name), ID Number ______________________

appoint ______________________ (Name) ______________________ (Address) ______________________ (Phone Number)

as my authorized representative for the purposes described in Sections 2 and 3 below. I understand this agreement is voluntary and made to confirm my direction. I understand that my authorized representative may further disclose my information, and it may not be protected by federal or state privacy laws.

Section 2: Scope of Authority

I authorize the disclosure of my protected health information to my authorized representative for the following purposes **(check only one)**:

☐ Disclose all of my claims regardless of dates of service, provider or diagnosis.

☐ Disclose my claim for this/these dates of service only ______________________

☐ Disclose all claims related to my diagnosis of ______________________ only

☐ Disclose all claims for this provider only ______________________

☐ Disclose all claims for ______________________ date(s) of service

☐ Other: ______________________

Section 3: Expiration and Revocation

Expiration: This authorized representative appointment will expire (check only one):

☐ On _____ /_____ /_____

☐ On the occurrence of the following event: ______________________

☐ Upon my revocation

Revocation: I understand that I may revoke this authorization at any time by giving written notice of my revocation to:

Name:______________________

Address:______________________

City, State, ZIP______________________

Phone Number: ______________________

I understand that revocation of this appointment will not affect any action you took in reliance on this appointment before you received my notice of revocation.

Section 4: Signature

I, ______________________, have had full opportunity to read and consider the contents of this appointment, and I confirm that the contents are consistent with my direction. I understand that, by signing this form, I am confirming my appointment of my authorized representative, the scope of my authorized representative's authority, the expiration of this appointment and the option of revoking of this appointment.

Signature: ______________________ Date:______________________

Please return this form to:

BlueCross BlueShield of South Carolina
Federal Employee Customer Service
P.O. Box 600601
Columbia, SC 29260-0601
Attention: Del Smith