Blue Cross and Blue Shield of Louisiana
HMO Louisiana

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

Fill Out the Form to Name an Authorized Delegate

For Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc.

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 Lousiana Blue) 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: 1-800-495-2583

Or call the number on the back of your member ID card.

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

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 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 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 Louisiana Blue 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 Louisiana Blue to no longer share my information or until my health insurance with Louisiana Blue 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 Louisiana Blue 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) 297-2727**
(225) 295-2494

Mail it to us at: **Customer Service**
Blue Cross and Blue Shield of Louisiana
Or HMO Louisiana
P.O. Box 98029
Baton Rouge, LA 70898-9029

Or
Email it to us at: **help@lablue.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 www.lablue.com/contactus.

Still have questions?

Call us. We will be happy to help you.

Call Customer Service at: 1-800-495-2583

Or call the number on the back of your member ID card.

Blue Cross and Blue Shield of Louisiana
HMO Louisiana
Southern National Life

Nondiscrimination Notice

Discrimination Is Against the Law

Blue Cross and Blue Shield of Louisiana and its subsidiaries, HMO Louisiana, Inc. and Southern National Life, comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. Louisiana Blue does not exclude people or treat them less favorably because of race, color, national origin, age, disability or sex.

Louisiana Blue and its subsidiaries:

- Provide people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, you can call the Customer Service number on the back of your ID card or email MeaningfulAccessLanguageTranslation@lablue.com. If you are hearing impaired call 1-800-711-5519 (TTY 711).

If you believe that Louisiana Blue or one of its subsidiaries failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you have the right to take the following steps:

1. If you are fully insured through Louisiana Blue or one of its subsidiaries, file a grievance in person or by mail, fax or email.

   Section 1557 Coordinator
   In Person: 5525 Reitz Ave. Baton Rouge, LA 70809
   Mail: P. O. Box 98012, Baton Rouge, LA 70898-9012
   Phone: (225) 298-7238 or 1-800-711-5519 (TTY 711)
   Fax: (225) 298-7240
   Email: Section1557Coordinator@lablue.com

2. If your employer sponsors a self-funded health plan and Louisiana Blue only serves as the Claims Administrator, contact your employer or your company's Human Resources Department. To determine if your plan is fully insured by Louisiana Blue or self-funded and sponsored by your employer, go to **www.lablue.com/checkmyplan**.

Whether you are fully insured or covered by a self-funded health plan, you can 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:

Mail: 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201
Phone: 1-800-368-1019, 1-800-537-7697 (TDD)

This notice is available at www.lablue.com.

NOTICE

Free language assistance services and auxiliary aids are available. If needed, please call the Customer Service number at 1-800-495-2583. Hearing-impaired customers call 1-800-711-5519 (TTY 711).

Tiene a su disposición servicios de asistencia lingüística y ayudas auxiliares gratuitas. Si necesita ayuda, llame al Servicio de Atención al Cliente al 1-800-495-2583. Los clientes con discapacidad auditiva pueden llamar al 1-800-711-5519 (TTY 711).

Des services d'assistance linguistique gratuits et des aides auxiliaires sont disponibles. Si nécessaire, veuillez appeler le numéro du service client au 1-800-495-2583. Les clients malentendants peuvent appeler le 1-800-711-5519 (ATS 711).

Có sẵn dịch vụ hỗ trợ ngôn ngữ miễn phí và các phương tiện hỗ trợ. Nếu cần, vui lòng gọi Dịch vụ khách hàng theo số 1-800-495-2583. Khách hàng khiếm thính vui lòng gọi 1-800-711-5519 (TTY 711).

免费提供语言协助服务和辅助工具。如有需要，请拨打客户服务电话 1-800-495-2583。听障客户请拨打 1-800-711-5519 (TTY 711)。

تتوفر خدمات مساعدة لغوية ووسائل مساعدة إضافية مجانية. وفي حال الحاجة إلى هذه الخدمات، يُرجى الاتصال بخدمة العملاء على الرقم 1-800-495-2583. يُرجى من العملاء ذوي الإعاقة السمعية الاتصال على الرقم 1-800-711-5519 (خدمة الهاتف النصي 711).

Mayroong mga libreng serbisyo sa tulong sa wika at karagdagang tulong. Kung kailangan ito, mangyaring tawagan ang numero ng Serbisyo sa Customer sa 1-800-495-2583. Para sa mga customer na may kapansanan sa pandinig, tumawag sa 1-800-711-5519 (TTY 711).

무료 언어 지원 서비스와 보조 도구를 이용하실 수 있습니다. 필요한 경우 고객 서비스 번호 1-800-495-2583으로 전화해 주시기 바랍니다. 청각 장애가 있는 고객은 1-800-711-5519(TTY 711)로 전화하십시오.

Serviços de assistência de idioma e demais auxílios disponíveis gratuitamente. Se necessário, ligue para o Atendimento ao Cliente no telefone 1-800-495-2583. Clientes com deficiência auditiva devem ligar para 1-800-711-5519 (TTY 711).

ມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ເຄື່ອງຊ່ວຍເສີມຟຣີ. ຖ້າຕ້ອງການ, ກະລຸນາໂທຫາບໍລິການລູກຄ້າ ທີ່ເບີ 1-800-495-2583. ລູກຄ້າທີ່ພິການຫູ ໃຫ້ໂທຫາ 1-800-711-5519 (TTY 711).

無料の言語アシスタンスサービスと介助用補助具をご利用いただけます。必要な場合は、カスタマーサービス番号1-800-495-2583までお電話ください。聴覚に障害のあるお客様は、1-800-711-5519 (TTY 711)までお電話ください。

زبان کے سلسلے میں مفت معاونت کی سہولیات اور اضافی معاونتیں دستیاب ہیں. ضرورت پڑنے پر کسٹمر سروس سے ان نمبر پر رابطہ کریں: 1-800-495-2583. سماعت کی کمی کے شکار افراد اس نمبر پر کال کریں: 1-800-711-5519 (TTY 711)

Bei Bedarf stehen Ihnen kostenlose Sprachhilfen und andere unterstützende Dienste zur Verfügung. Bitte wenden Sie sich dazu telefonisch an den Kundenservice unter 1-800-495-2583. Sollten Sie schwerhörig sein, wählen Sie bitte die 1-800-711-5519 (TTY 711).

خدمات کمک زبانی رایگان و ابزارهای کمکی جانبی در دسترس هستند. در صورت نیاز، لطفاً با «خدمات مشتریان» به شماره 1-800-495-2583 تماس بگیرید. مشتریان کم‌شنوا با 1-800-711-5519 (TTY 711) بگیرند.

Мы предоставляем бесплатные услуги языковой поддержки и вспомогательное оборудование. При необходимости позвоните в службу поддержки клиентов по номеру 1-800-495-2583. Телефон для клиентов с нарушениями слуха — 1-800-711-5519 (TTY 711).

มีบริการช่วยเหลือด้านภาษาและเครื่องสนับสนุนฟรี หากจำเป็น โปรดโทรติดต่อฝ่ายบริการลูกค้าได้ที่หมายเลข 1-800-495-2583 ลูกค้าที่มีความบกพร่องทางการได้ยิน โปรดโทรไปที่หมายเลข 1-800-711-5519 (TTY 711)