



**BlueCross BlueShield
of New Mexico**

Restriction Request Form

Use this form to request restrictions on Blue Cross and Blue Shield of New Mexico' use or disclosure of your Protected Health Information (PHI) for payment or health care operations purposes. You may also use this form to terminate a previously granted request for restriction.

PLEASE NOTE: DO NOT USE THIS FORM TO SIMPLY CHANGE YOUR ADDRESS.

If you need assistance in completing this form, or with a change of address, please call the Customer Service number listed on the back of your Member Identification Card.

**WHEN COMPLETED AND SIGNED PLEASE MAIL TO: Blue Cross and Blue Shield of New Mexico
P.O. Box 805106
Chicago, IL 60680-4112**

Section A: Restriction Request or Termination	
Is this form being used to terminate a previously approved request for Restriction? If "Yes", complete Section B, then proceed to Section D. If "No", then complete the form entirely.	
<input type="checkbox"/> Yes – Enter date to terminate previous request:	_____
<input type="checkbox"/> No	Date: month/day/year

Section B: The individual for whom restriction is being requested. Please complete the following:					
Name _____		Group # _____		Identification\Subscriber # _____	
Social Security Number _____		Date of Birth _____			
Address _____		City _____		State _____	ZIP _____
Area Code & Telephone Number _____		E-mail address (if available) _____			

Section C: Please specify your Protected Health Information (PHI) that you want restricted:

Please state how you would like to restrict the use and disclosure of this information:

Please indicate if this restriction request should apply to communicating your PHI to your Health Savings Account (HSA) or Flexible Savings Account (FSA), if applicable:
<input type="checkbox"/> Yes <input type="checkbox"/> No



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If this request is granted, please note the following:

- 1. The request will only apply to your current Group and Subscriber Numbers and benefits coverage. If your Group or Subscriber Numbers change, or your benefits coverage changes (i.e., dental coverage is added), you must submit a new Restriction Request for the new group/subscriber number or benefit coverage.**
- 2. This request will expire eighteen (18) months after your benefits coverage has terminated.**
- 3. Blue Cross and Blue Shield of New Mexico and its Business Associates are only responsible for the PHI that they release in accordance with your designation in Section C.**

Section D: Signature - This document must be signed by the individual, parent of minor child or the individual's Personal Representative.	
<p>I request that Blue Cross and Blue Shield of New Mexico (BCBSNM) restrict the use or disclosure of my PHI as specified in Section C above. I understand that Blue Cross and Blue Shield of New Mexico is under no obligation to agree to my request. I understand I will receive a written determination regarding my request. I understand that if I am signing on behalf of a minor child, this request will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.</p>	
_____ Signature	_____ Date: month/day/year

Section E: If Section D is signed by a Personal Representative, please complete the information below:			
<p>If you are signing as a Power of Attorney, Legal Guardian, Executor, or Administrator, attach a copy of the Legal documents. You do NOT have to attach copies of these documents if they are already on file with Blue Cross and Blue Shield of New Mexico.</p>			
_____ Personal Representative's Name		_____ Relationship to Individual	
_____ Personal Representative's Address	_____ City	_____ State	_____ ZIP
_____ Personal Representative's Area Code & Telephone Number		_____ Personal Representative's E-mail address (if available)	