BlueCross BlueShield of New Mexico

Dear Member:

We need your okay before we can give out your records to others. Just fill out and sign this form.

We've been asked to release your records to a person or company. Before we can do this, we need you to fill out the form that is with this letter. Then send it back to us. This form will tell us who can receive your records.

The form will be good for one year from the date you sign it unless you ask for it to end sooner.

Please be sure to fill out the whole form. Keep a copy for your records. Please don't change the form or leave things out. If there are problems, or if we have questions, we'll send you a letter or call you.

Once we get your signed form, we will process it quickly. If you have any questions, please call Customer Service at 1-866-689-1523.

Sincerely,

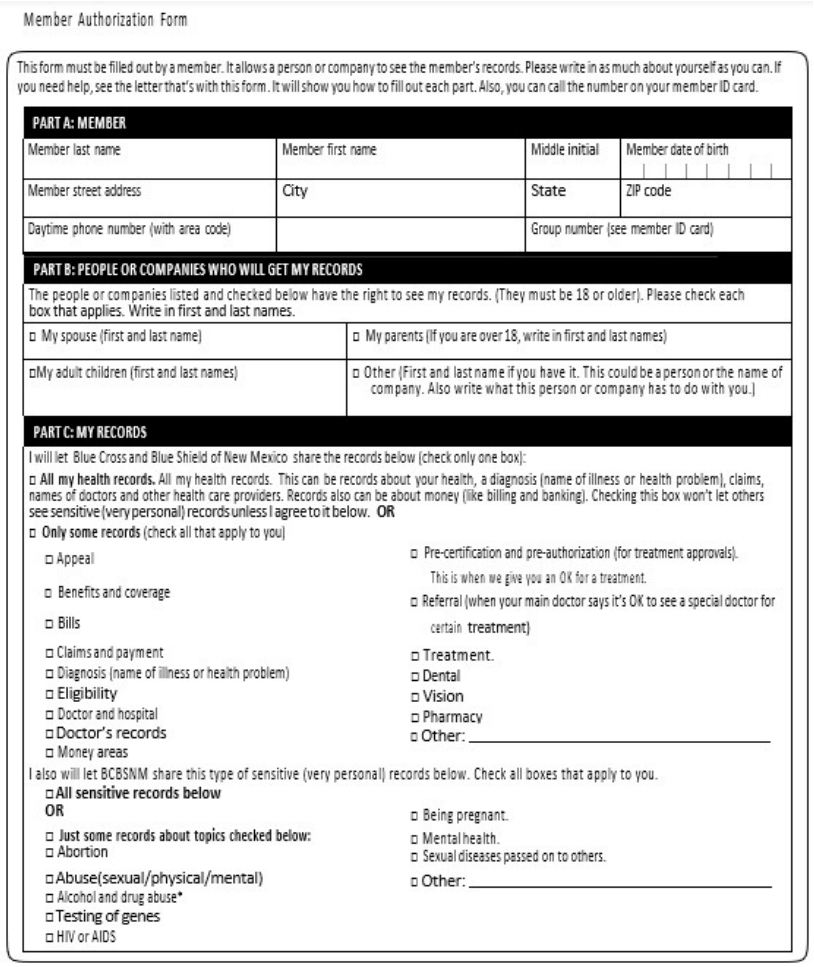
Customer Advocate

BlueCross BlueShield of New Mexico

Please read the following for help completing page one of the form.

PART A: Member

- Print your last name, first name, and the first letter of your middle name.
- 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.
- Write your full street address, city, state, and ZIP code.
- Write a daytime phone number (including area code) where you can be reached.
- ***Member ID number***
  - This number is on your member ID card.
- ***Group number***
  - This number is on your member ID card. If your ID card does not have a group number, leave this part blank.



Member Authorization Form

This form must be filled out by a member. It allows a person or company to see the member's records. Please write in as much about yourself as you can. If you need help, see the letter that's with this form. It will show you how to fill out each part. Also, you can call the 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
Daytime phone number (with area code)		Group 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 company. Also write what this person or company has to do with you.)

PART C: MY RECORDS

I will let Blue Cross and Blue Shield of New Mexico share the records below (check only one box):

◻ **All my health records.** 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)

◻ Appeal
◻ Benefits and coverage
◻ Bills
◻ Claims and payment
◻ Diagnosis (name of illness or health problem)
◻ Eligibility
◻ Doctor and hospital
◻ Doctor's records
◻ Money areas
◻ Pre-certification and pre-authorization (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 also will let BCBSNM share this type of sensitive (very personal) records below. Check all boxes that apply to you.

◻ **All sensitive records below**
OR
◻ **Just some records about topics checked below:**
◻ Abortion
◻ Abuse(sexual/physical/mental)
◻ Alcohol and drug abuse*
◻ Testing of genes
◻ HIV or AIDS
◻ Being pregnant.
◻ Mental health.
◻ Sexual diseases passed on to others.
◻ Other: _____

PART B: People or companies who will get my records

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

PART C: My records

- Tell us what records you will let us give out: all or just some.
- To give out all of your records, check the first box.
- To give out only some records, check the second box.
- There is also a section about things that you think are very personal or very private to you. If you agree that we can give out these types of records, check the boxes that apply to you.

BlueCross BlueShield
of New Mexico

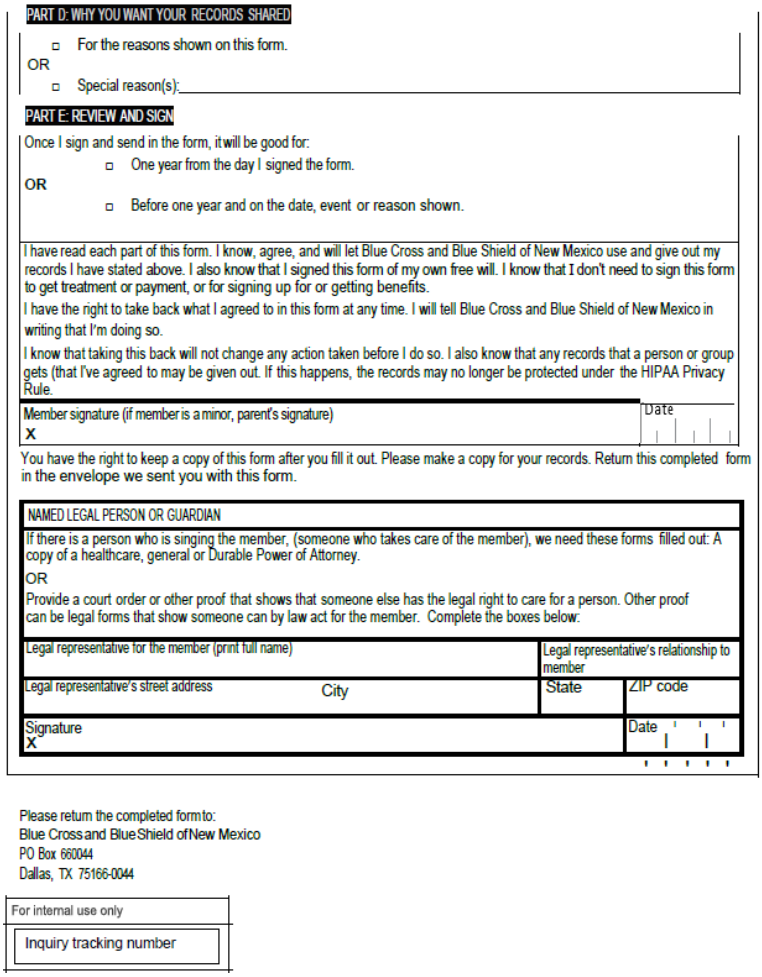
Please read the following for help completing page two of the form.

PART D: Why you want your records shared

- The first box tells us to give out your records as shown on this form.
- The second box tells us a special reason. This could be talking about a life insurance claim. This might be with a lawyer or family member. Write your reason in the space.

PART E: Review and sign

- Once you sign the form, it will be good for one of the following amounts of time:
  - Check the first box for one year. That's the normal time.
  - 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.
- **Sign your name and put the date on the form.** Your name and signature ***must*** match what you wrote in PART A.
- You may be signing this form for someone else. If you have forms that say 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. Put it in with this form.



PART D: WHY YOU WANT YOUR RECORDS SHARED

☐ For the reasons shown on this form.
OR
☐ Special reason(s):_____

PART E: REVIEW AND SIGN

Once I sign and send in the form, it will be good for:
☐ One year from the day I signed the form.
OR
☐ Before one year and on the date, event or reason shown.

I have read each part of this form. I know, agree, and will let Blue Cross and Blue Shield of New Mexico use and give out my records 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 Cross and Blue Shield of New Mexico 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 gets (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) X | Date

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

NAMED LEGAL PERSON OR GUARDIAN

If there is a person who is singing the member, (someone who takes care of the member), we need these forms filled out: A copy of a healthcare, general or Durable Power of Attorney.
OR
Provide a court order or other proof that shows that someone else 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. Complete the boxes below:

Legal representative for the member (print full name) | Legal representative's relationship to member
Legal representative's street address | City | State | ZIP code
Signature X | Date

Please return the completed form to:
Blue Cross and Blue Shield of New Mexico
PO Box 660044
Dallas, TX 75166-0044

For internal use only
Inquiry tracking number

Here are samples of legal forms. These are 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 him or herself.
- **Executor of estate**. This type of form would be used when the person who is being spoken for has died.

Member Authorization Form

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PART A: MEMBER

Member last name	Member first name	Middle initial	Member date of birth
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Daytime phone number (with area code)		Group number (see member ID card)	

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□ **Only some records** (check all that apply to you)

□ Appeal
□ Benefits and coverage
□ Bills
□ Claims and payment
□ Diagnosis (name of illness or health problem)
□ Eligibility
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□ Doctor's records
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□ Pre-certification and pre-authorization (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 also will let BCBSNM share this type of sensitive (very personal) records below. Check all boxes that apply to you.

□ **All sensitive records below**
OR
□ **Just some records about topics checked below:**
□ Abortion
□ Abuse(sexual/physical/mental)
□ Alcohol and drug abuse*
□ Testing of genes
□ HIV or AIDS
□ Being pregnant.
□ Mental health.
□ Sexual diseases passed on to others.
□ Other: _____

*I know that my alcohol and drug abuse records are protected under federal 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, or as stated below in Part E. I know that I cannot cancel this signed form after we have given out your health records.

PART D: WHY YOU WANT YOUR RECORDS SHARED

☐ For the reasons shown on this form.

OR

☐ Special reason(s):_____

PART E: REVIEW AND SIGN

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

☐ One year from the day I signed the form.

OR

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

I have read each part of this form. I know, agree, and will let Blue Cross and Blue Shield of New Mexico use and give out my records 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 Cross and Blue Shield of New Mexico 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 gets (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) **X**	Date

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

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OR

Provide a court order or other proof that shows that someone else 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. Complete the boxes below:

Legal representative for the member (print full name)		Legal representative's relationship to member
Legal representative's street address	City / State	ZIP code
Signature **X**		Date / /

Please return the completed form to:
Blue Cross and Blue Shield of New Mexico
PO Box 660044
Dallas, TX 75166-0044

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BlueCross BlueShield of New Mexico

Non-Discrimination Notice

Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids or language assistance free of charge, please call us at **1-866-689-1523**.

If you believe we have failed to provide a service, or think we have discriminated in another way, you can file a grievance with:

Office of Civil Rights Coordinator
Attn: Office of Civil Rights Coordinator
300 E. Randolph St., 35th Floor
Chicago, IL 60601

Phone: **1-855-664-7270** (voicemail)
TTY/TDD: **1-855-661-6965**
Fax: **1-855-661-6960**
Email: civilrightscoordinator@bcbsil.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You may file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, at:

US Dept of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201

Phone: **1-800-368-1019**
TTY/TDD: **1-800-537-7697**
Complaint Portal:
ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Complaint Forms:
hhs.gov/civil-rights/filing-a-complaint/index.html

If you are a Blue Cross and Blue Shield of New Mexico Medicaid member, this notice is available on our website at bcbsnm.com/turquoise-care/legal-and-privacy/non-discrimination-notice.

Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

BlueCross BlueShield of New Mexico

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-866-689-1523 (TTY: 711) or speak to your provider.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-866-689-1523 (TTY: 711) o hable con su proveedor.
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-866-689-1523 (TTY: 711) أو تحدث إلى مقدم الخدمة.
中文 Chinese	注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-866-689-1523（文本电话：711）或咨询您的服务提供商。
Français French	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-866-689-1523 (TTY : 711) ou parlez à votre fournisseur.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-866-689-1523 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-866-689-1523 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-866-689-1523 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Italiano Italian	ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'1-866-689-1523 (tty: 711) o parla con il tuo fornitore.
한국어 Korean	주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-866-689-1523 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	SHOOH: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 1-866-689-1523 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.
فارسي Farsi	توجه: اگر [وارد کردن زبان] صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 855-710-6984 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.

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Polski Polish	UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-866-689-1523 (TTY: 711) lub porozmawiaj ze swoim dostawcą.
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-866-689-1523 (TTY: 711) или обратитесь к своему поставщику услуг.
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-866-689-1523 (TTY: 711) o makipag-usap sa iyong provider.
اردو Urdu	توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔-1 866-689-1523 (TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-866-689-1523 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.