BlueCross BlueShield of North Carolina

Date

Name
Address
City, State, Zip

Patient:
Date of Birth:
Date(s) of Service:
Provider:
Reference Inquiry:
Regarding:

I have given my permission for _____to represent me, and act on my behalf regarding the above-referenced denial for the following services _____.

I authorize Blue Cross and Blue Shield of North Carolina (BCBSNC) to release any of my protected health information (PHI) to my representative named above for the purpose of resolving my appeal.

I understand that I may revoke this authorization at any time by mailing a written notice to BCBSNC at the address below. I understand that revoking this authorization will not affect any action that BCBSNC has taken prior to receiving my notice of revocation.

I further understand that BCBSNC will not condition the provision of my health plan benefits because of this authorization.

I further understand that the person(s) that I have given permission to receive my PHI may not be subject to federal health information privacy laws and that they may disclose my information and it may no longer be protected by federal health information privacy laws.

This authorization will expire upon resolution of this appeal.

Thank you.

_____ _____
Member Signature Date