blue shield of california

Appointment of representative

Use this form to authorize Blue Shield of California, Blue Shield of California Life & Health Insurance Company, and their business associates (collectively "Blue Shield") to allow an appointment of representation in connection with my appeal or grievance. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance, or request wholly in my stead. I understand that personal medical information related to my request may be disclosed to the representative indicated below.

1. Person appointing a representative ("Member")

Member name:

Member address:

Subscriber ID number:

Date of birth:

2. Who is the appointed representative?

Recipient's name:

Recipient's address:

Recipient's relationship to the Member:

3. What is the purpose of completing this form? (Check one)

☐ Appoint a representative

☐ Revoke an existing appointment of representative

4. Expiration and revocation.

This Appointment of Representation will remain in effect for one year from the date you sign it (below) unless a different date is specified here: ___/_____/_____

You have the right to revoke this Appointment of Representation at any time by notifying Blue Shield in writing. Revoking this Appointment of Representation will not affect Information we use or disclose before we receive your revocation request. If this Appointment of Representation is given by a parent or legal guardian on behalf of a minor, it will expire on the minor's eighteenth birthday.

5. Signature of member and representative

I have read this form and I understand and agree to its terms. I direct Blue Shield of California to allow an appointment of representation to use or disclose the Information to the noted recipient as directed above. This may include health information like substance abuse, mental health, behavioral health, genetic testing, and HIV/AIDS status. I understand that once my information is disclosed, it could be re-disclosed by the recipient and may no longer be protected by privacy laws, including the federal Health Insurance Portability and Accountability Act of 1996.

I understand that Blue Shield may not condition payment, enrollment in a health plan, or eligibility for benefits on whether I sign this Appointment of Representation.

_____ _____

Member signature Date

_____

Member's name (print)

By signing below, I have read this form and hereby accept the above appointment.

_____ _____

Representative signature Date

_____

Representative's name (print)

Legal representatives or guardians

If this form is signed by someone other than the member or the parent of a minor, such as a personal/legal representative, guardian, or executor, **you must also submit legal documentation** showing your authority to act on behalf of the Member (or the Member's estate) to release health information. Such documentation may include, for example:

1. Durable Health Care Power of Attorney
2. Current, valid documentation of court-ordered guardianship; or
3. Other valid legal documentation showing your authority to act on behalf of the Member (or the Member's estate)

Representative's name (print): _____

Relationship to Member: _____

Type of documentation submitted: _____

Keep a copy of the Appointment of Representative form for your records

Return the completed and signed appointment of representative form to:

Blue Shield of California Customer Care
P.O. Box 272540
Chico, CA 95927-2540

The company complies with applicable state laws and federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, ethnic group identification, medical condition, genetic information, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, mental disability, or physical disability.

La compañía cumple con las leyes de derechos civiles federales y estatales aplicables, y no discrimina, ni excluye ni trata de manera diferente a las personas por su raza, color, país de origen, identificación con determinado grupo étnico, condición médica, información genética, ascendencia, religión, sexo, estado civil, género, identidad de género, orientación sexual, edad, ni discapacidad física ni mental.

本公司遵守適用的州法律和聯邦民權法律，並且不會以種族、膚色、原國籍、族群認同、醫療狀況、遺傳資訊、血統、宗教、性別、婚姻狀況、性別認同、性取向、年齡、精神殘疾或身體殘疾而進行歧視、排斥或區別對待他人。