Amerigroup

myamerigroup.com/tn

Amerigroup Community Care

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

Dear Member:

To ensure your privacy, we need you to fill out the form included with this letter. Once you complete the form, please send it back to us. This form will let us know who you are allowing to view your records.

The form is 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, and keep a copy for your records. Please don't change the form or leave things out. If we have questions or there are problems with the form, we'll send you a letter or call you.

We will quickly process your form once we receive it. If you have any questions, call the Member Services number on your ID card and ask to speak to the Member Privacy Unit.

Sincerely,

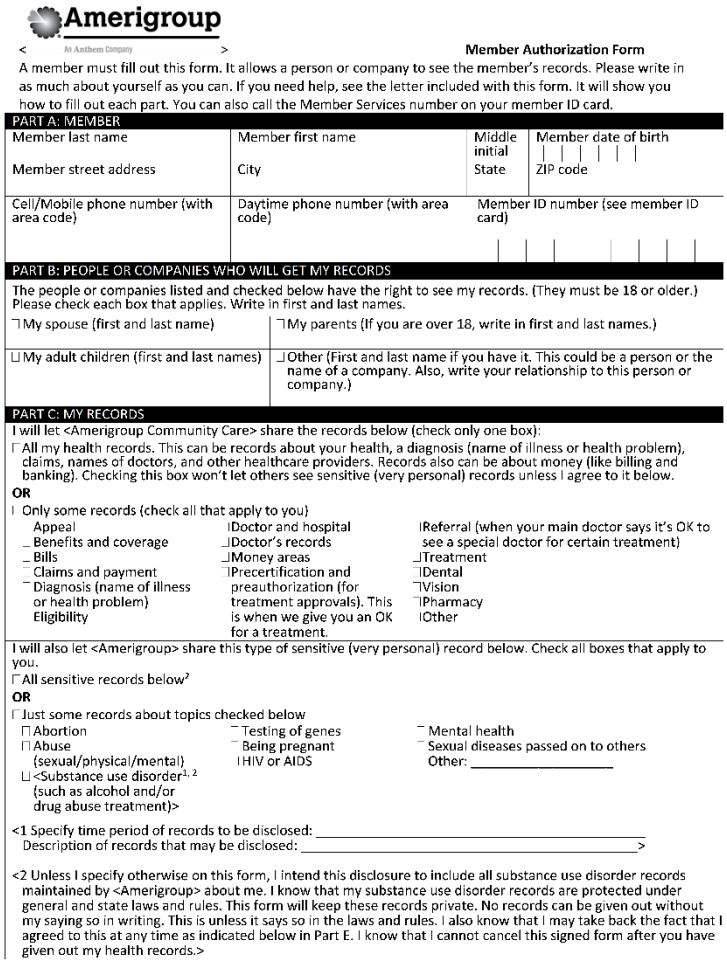
Member Privacy Unit
Amerigroup Community Care

Enclosures: Nondiscrimination notice
Receive help in another language

Please read this page for help completing page 1 of the form.

PART A: Member

1. Print your last name, first name, and the first letter of your middle name.
2. 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.
3. Write your full street address, city, state, and ZIP code.
4. Write a daytime phone number (with area code) where to reach you.
5. Write your cell/mobile phone number (with area code) where to reach you.
6. Member ID number is on your member ID card.



Amerigroup
An Anthem Company

Member Authorization Form

A member must fill out this form. 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 included with this form. It will show you how to fill out each part. You can also call the Member Services 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
Cell/Mobile phone number (with area code)	Daytime phone number (with area code)	Member ID 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 a company. Also, write your relationship to this person or company.)

PART C: MY RECORDS

I will let <Amerigroup Community Care> share the records below (check only one box):

☐ 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 healthcare 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
- ☐ Precertification and preauthorization (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 will also let <Amerigroup> share this type of sensitive (very personal) record below. Check all boxes that apply to you.

☐ All sensitive records below[2]

OR

☐ Just some records about topics checked below

- ☐ Abortion
- ☐ Abuse (sexual/physical/mental)
- ☐ <Substance use disorder[1, 2] (such as alcohol and/or drug abuse treatment)>
- ☐ Testing of genes
- ☐ Being pregnant
- ☐ HIV or AIDS
- ☐ Mental health
- ☐ Sexual diseases passed on to others
- Other: _____

<1 Specify time period of records to be disclosed: _____

Description of records that may be disclosed: _____>

<2 Unless I specify otherwise on this form, I intend this disclosure to include all substance use disorder records maintained by <Amerigroup> about me. I know that my substance use disorder records are protected under general 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 as indicated below in Part E. I know that I cannot cancel this signed form after you have given out my health records.>

PART B: People or companies who can see my records

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

PART C: My records

Tell us what records you will allow us to give out (all or just some):

9. To give out all of your records, check the first box.
10. To give out only some records, check the second box.
11. This section also includes records you think are very personal or very private to you. If you agree we can give out these types of records, check which boxes apply to you.

Please read this page for help completing page 2 of the form.

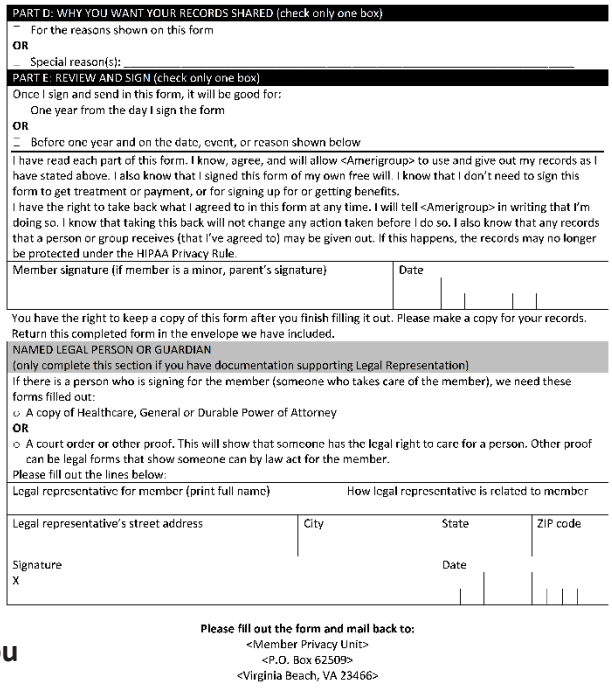
PART D: Why you want your records shared

1. The first box tells us to give out your records as shown on this form.
2. The second box tells us a special reason. 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:

3. Check the first box for one year. This is the normal time.
4. 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.
5. **Sign your name and put the date on the form.** Your name and signature *must* match what you wrote in Part A.
6. **If you are signing this form for someone or if you have forms saying you have Power of Attorney for healthcare, 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. Include it with this form.



PART D: WHY YOU WANT YOUR RECORDS SHARED (check only one box)

☐ For the reasons shown on this form

OR

☐ Special reason(s): _____

PART E: REVIEW AND SIGN (check only one box)

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

One year from the day I sign the form

OR

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

I have read each part of this form. I know, agree, and will allow <Amerigroup> to use and give out my records as 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 <Amerigroup> 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 receives (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)	Date

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

NAMED LEGAL PERSON OR GUARDIAN

(only complete this section if you have documentation supporting Legal Representation)

If there is a person who is signing for the member (someone who takes care of the member), we need these forms filled out:

○ A copy of Healthcare, General or Durable Power of Attorney

OR

○ A court order or other proof. This will show that someone 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.

Please fill out the lines below:

Legal representative for member (print full name)		How legal representative is related to member	
Legal representative's street address	City	State	ZIP code
Signature X		Date	

Please fill out the form and mail back to:
<Member Privacy Unit>
<P.O. Box 62509>
<Virginia Beach, VA 23466>

Here are samples of legal forms used when a person needs someone else to make choices for them.

- **Healthcare, General or Durable Power of Attorney.** This form gives someone the legal power to act for you. This person can make healthcare 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 themselves.
- **Executor of estate.** This type of form is used when the person who is being spoken for has died.

Amerigroup

Member Authorization Form

A member must fill out this form. 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 included with this form. It will show you how to fill out each part. You can also call the Member Services 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
Cell/Mobile phone number (with area code)	Daytime phone number (with area code)	Member ID 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 a company. Also, write your relationship to this person or company.)

PART C: MY RECORDS

I will let Amerigroup Community Care share the records below (check only one box):

☐ 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 healthcare 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
- ☐ Precertification and preauthorization (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 will also let Amerigroup share this type of sensitive (very personal) record below. Check all boxes that apply to you.

☐ All sensitive records below[2]

OR

☐ Just some records about topics checked below

- ☐ Abortion
- ☐ Abuse (sexual/physical/mental)
- ☐ Substance use disorder[1, 2] (such as alcohol and/or drug abuse treatment)
- ☐ Testing of genes
- ☐ Being pregnant
- ☐ HIV or AIDS
- ☐ Mental health
- ☐ Sexual diseases passed on to others
- ☐ Other: _____

1 Specify time period of records to be disclosed: _____
Description of records that may be disclosed: _____

2 Unless I specify otherwise on this form, I intend this disclosure to include all substance use disorder records maintained by Amerigroup about me. I know that my substance use disorder records are protected under general 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 as indicated below in Part E. I know that I cannot cancel this signed form after you have given out my health records.

PART D: WHY YOU WANT YOUR RECORDS SHARED (check only one box)

☐ For the reasons shown on this form

OR

☐ Special reason(s): _____

PART E: REVIEW AND SIGN (check only one box)

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

☐ One year from the day I sign the form

OR

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

I have read each part of this form. I know, agree, and will allow Amerigroup to use and give out my records as 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 Amerigroup 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 receives (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)	Date

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

NAMED LEGAL PERSON OR GUARDIAN
(only complete this section if you have documentation supporting Legal Representation)

If there is a person who is signing for the member (someone who takes care of the member), we need these forms filled out:

- A copy of Healthcare, General or Durable Power of Attorney

OR

- A court order or other proof. This will show that someone 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.

Please fill out the lines below:

Legal representative for member (print full name)	How legal representative is related to member

Legal representative's street address	City	State	ZIP code

Signature X	Date

Please fill out the form and mail back to:

Member Privacy Unit
P.O. Box 62509
Virginia Beach, VA 23466