NATIONAL BENEFIT ADMINISTRATORS, INC.
PO BOX 690903
CHARLOTTE, NC 28227

MEMBER'S AUTHORIZATION REQUEST FORM

You may give National Benefit Administrators (NBA) written authorization to disclose your protected health information (PHI) to anyone that you designate and for any purpose. If you wish to authorize a person or entity to receive your PHI, please complete the information below. **Completion of this form will not change the way that NBA communicates with members or subscribers.** ***For example, we will send explanation of benefits (EOB) statements to the subscriber.***

MEMBER WHOSE INFORMATION WILL BE DISCLOSED:

_____

MEMBER'S FIRST NAME M.I. MEMBER'S LAST NAME

MONTH DAY YEAR **ID NUMBER**

☐☐/☐☐/☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐☐☐

MEMBER'S DATE OF BIRTH SUBSCRIBER ID NUMBER (FROM YOUR ID CARD)

At my request, I authorize NBA to disclose Protected Health Information to (*enter name of person/entity who will receive member's PHI):*

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐ ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

FIRST NAME M.I. LAST NAME

RELATIONSHIP TO MEMBER: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Please provide the following information to the person you have authorized so that we may verify the person's identity and authority to receive your PHI: **(i)** your subscriber ID number, **(ii)** your date of birth, and **(iii)** subscriber address.

I authorize NBA to disclose the following PHI to the person/entity listed above. CHECK ONLY BOXES THAT APPLY.

☐ ALL Information Requested ☐ Enrollment Information ☐ Benefit Information ☐ Premium Payment Information ☐ Explanation of Benefits (EOB) Information

☐ All Claims Information ☐ All Services from a Specific Health Care Provider(s) *(List Provider's Name)*: _____

☐ Other *(Please List Specific PHI and/or Date Ranges)*: _____

NOTE: If you would like this authorization to become effective on a date after NBA enters the authorization into its system, please insert the date:

MONTH DAY YEAR

☐☐/☐☐/☐☐☐☐

I understand that I may revoke this authorization at any time by giving NBA written notice mailed to the address below. However, if I revoke this authorization, I also understand that the revocation will <u>not</u> affect any action NBA took in reliance on this authorization before NBA received my written notice of revocation.
I also understand that NBA will not condition the provision of health plan benefits on this authorization.
I also understand that if the persons or entities I authorize to receive my PHI are not health plans, covered health care providers or health care clearinghouses subject to the Health Insurance Portability and Accountability Act ("HIPAA") or other federal health information privacy laws, they may further disclose the PHI and it may no longer be protected by HIPAA or federal health information privacy laws.

Signature: _____ **Today's Date:** _____

If signed by an individual other than the member *(Print your full name)*: _____
Describe your authority to act for the member *(e.g., power of attorney, court order, parent of minor child, etc.)*: _____
NOTE: Please attach the legal document naming you as the personal representative if you have not previously submitted it to us.

RETURN THIS AUTHORIZATION TO: **NATIONAL BENEFIT ADMINISTRATORS, INC., PO BOX 690903, CHARLOTTE, NC 28227**