BlueCross BlueShield of Texas

Phone Number: (866) 628-2606
Fax: (877) 404-6457

AUTHORIZATION TO EXCHANGE MEDICAL AND OTHER INFORMATION FOR CLAIM ADMINISTRATION

Return to Blue Cross and Blue Shield of Texas at:
Attention Claims Department
P.O. Box 7071
Downers Grove, IL 60515

Note: Blue Cross and Blue Shield of Texas (BCBSTX) / Dearborn Life Insurance Company doing business as BCBSTX

You are authorized to exchange information with the above-named entities related to my health condition, job modifications or accommodations to:

- administer any benefit plan under which I may be a participant; and
- identify any programs for which I may qualify.

This form allows the release and exchange of the following information, collectively referred to as "Information":

- Records, office notes, test results, diagnostic imaging studies, data, and information about health care history, diagnosis, prognosis, treatment, rehabilitation, vocational testing, examinations and prescriptions;
- Employment-related information, including any claims for workers' compensation, no fault in; and
- Information regarding insurance coverage or pension benefits, including claims submitted and benefits paid.

I understand that the Information being disclosed may include protected health information under the Health Insurance Portability and Accountability Act of 1996 and accompanying regulations (HIPAA), information regarding mental health conditions and the use of drugs or alcohol, and information regarding the human immunodeficiency virus (HIV).

I understand that the Information will be used for the purpose of evaluating, managing and/or administering benefits for short-term disability, long-term disability, salary continuation, workers' compensation, which are excepted benefits under HIPAA, or any other benefit program offered by and through the employer (hereinafter collectively referred to as "Benefits Program"), developing a vocational rehabilitation plan, and other purposes in connection with the administration of the Benefits Program.

I further authorize re-disclosure of any Information obtained or developed in the course of managing and/or administering the Benefits Program to the plan administrator or claim administrator of any Benefits Program under which I may be a participant, employers, reinsurers, the Social Security Administration (SSA), claims investigators, attorneys, physician consultants and other service providers, including treating physician(s), solely for the purpose of evaluating, analyzing, managing and/or administering the Benefits Program. I understand that information re-disclosed pursuant to this authorization may not be protected under HIPAA.

I understand that this authorization shall remain valid during the duration of my claim or such shorter period as mandated by applicable law. I also understand that I have the right upon request to receive a copy of this authorization. I agree that a photocopy of this authorization shall be as valid and effective as the original.

I understand that I have the right to refuse to sign this authorization and that this authorization is subject to revocation at any time by my giving written notice that is signed by me to the address below. I understand that any such revocation shall not apply to any disclosure or re-disclosure of Information made in reliance on my initial authorization. I also understand that my failure to sign this authorization, or my subsequent revocation of this authorization, may impair the ability of BCBSTX to process my claim for disability benefits and may lead to the denying or terminating of my claim for disability benefits.

To Be Completed by Employee:

Employee's Signature: _____ Date: _____

Employee's Full Name: _____ Date of Birth: _____

If the Employee is unable to sign, an authorized representative may sign below for the Employee:

Representative's Signature: _____ Date: _____

Before sending this form, make a copy for your records:

- Photocopy this signed authorization, or
- Complete and sign the duplicate form you received or printed

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