

Authorized Personal Representative (APR) Form

This form allows a member to designate an Authorized Personal Representative (APR), such as a spouse, parent, Power of Attorney, or broker/agent. Blue Cross and Blue Shield of Louisiana (Blue Advantage) may share protected health information (“PHI”) with a member’s APR. PHI may include viewing payment, claims or authorization history, or filing or responding to appeals. A member’s APR may also act on the member’s behalf and make changes to the member’s account, such as changing primary care provider, demographic or contact information, or making payments on an account. **Mark the options in Section C below for what information your APR may view or change.**

Instructions: Please complete all sections of this APR Form and return to Blue Advantage.

Section A - Member Information (* - required fields): List the Member whose information is to be shared.

*Name:	*Date of Birth:
*Phone Number:	*Health Plan ID, MBI <i>or</i> SSN:
*Address:	
*City:	*State: *Zip:

Section B - Person or Organization to Receive Information (* - required fields): List the specific person or entity that can receive, access or change the Member’s information.

Effective Date:	Termination Date: (APRs will term automatically after 365 days)
*Person/Entity Name:	*Date of Birth:
*Phone Number:	SSN (Optional):
*Address:	
*City:	*State: *Zip:
Relationship to Member: <input type="checkbox"/> Attorney <input type="checkbox"/> Family member <input type="checkbox"/> Agent/Broker <input type="checkbox"/> Facility <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Guardian <input type="checkbox"/> Employee of Agent/Broker <input type="checkbox"/> Other	

Section C - Access Details: Mark the options below to allow your APR to access and/or change each type of information. Options left unmarked below will not be available to your APR.

My representative can (mark all that apply):

- | | |
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| <input type="checkbox"/> View my PHI/Medical information | <input type="checkbox"/> View or change my primary care provider |
| <input type="checkbox"/> File or respond on my behalf regarding an appeal or grievance | <input type="checkbox"/> View or change my demographic or contact information |
| <input type="checkbox"/> View information on my infectious diseases | <input type="checkbox"/> View my family relationships |
| <input type="checkbox"/> View information on my mental health | <input type="checkbox"/> View my Power of Attorney |
| <input type="checkbox"/> View information on my chemical or substance dependency | <input type="checkbox"/> View my payment history |

Section D - Member Signature (required): I understand by signing this form, I have read and understand that Blue Advantage has permission to release my PHI to and accept changes or actions made on my behalf by this person or entity as well. If no effective date is listed in Section B, the effective date for these permissions is indicated below. I understand that I must contact Blue Advantage to change or terminate this appointment.

Signature: _____	Date: _____
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Section E - Acceptance of Appointment (required): I, _____, hereby accept the above appointment. I certify that I am not disqualified from acting as the Member’s Authorized Personal Representative.

Signature: _____	Date: _____
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