Louisiana
Blue Advantage (HMO) | Blue Advantage (PPO)

**RETURN COMPLETED FORM TO:**
Medicare Enrollment Fax: (877) 553-6152

# 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.**

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**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 *or* 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:
- ☐ Attorney
- ☐ Family member
- ☐ Agent/Broker
- ☐ Facility
- ☐ Power of Attorney
- ☐ Guardian
- ☐ Employee of Agent/Broker
- ☐ 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*):**

- ☐ View my PHI/Medical information
- ☐ File or respond on my behalf regarding an appeal or grievance
- ☐ View information on my infectious diseases
- ☐ View information on my mental health
- ☐ View information on my chemical or substance dependency
- ☐ View or change my primary care provider
- ☐ View or change my demographic or contact information
- ☐ View my family relationships
- ☐ View my Power of Attorney
- ☐ 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:

**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:

Blue Cross and Blue Shield of Louisiana HMO offers Blue Advantage (HMO). Blue Cross and Blue Shield of Louisiana, an independent licensee of the Blue Cross Blue Shield Association, offers Blue Advantage (PPO).