Authorization for release of information

I, _____ hereby authorize Health Advantage, their directors, officers, employees and agents, to disclose to _____ all information or data in any form, whether oral, written, electronic, video, or computer data, which relates to or references _____. The information which I hereby authorize to be disclosed shall include, but shall not be limited to any information showing, relating to or arising from: (I) any benefit claims, or the processing, payment, denial or appeal of such claims; or (ii) the services provided by Health Advantage; or (iii) any medical records, notes, or documents of any kind; or (iv) any communications, notes or statements of any person or entity regarding or relating to any of the foregoing. This authorization shall remain valid and effective until such time as I have delivered written notice to either the person at Health Advantage who obtained this authorization from me or to an officer of Health Advantage that I intend to revoke the authorization. I understand and agree that this authorization shall apply to all information disclosed by Health Advantage prior to the time that my written notice of revocation is actually received by either the person who obtained it from me or an officer of Health Advantage, as referenced above.

Signature

Date signed (mm/dd/yyyy)

Print name

Member ID number

The request must be mailed or faxed to:
Arkansas Blue Cross and Blue Shield
Attn: Customer Service
PO Box 2181
Little Rock, AR 72203

For Metallic Plan Members (Gold, Silver, Bronze Catastrophic)
Fax number: 501-378-2562

For all other members (including dental and non-metallic medical plans):
Fax number: 501-212-8518