RESET

Horizon

Horizon Blue Cross Blue Shield of New Jersey

Authorization For Disclosure OR Request For Access To Protected Health Information

Read instructions on p. 2 before completing this form. ALL FIELDS MUST BE COMPLETED.

Instructions: To authorize the use and disclosure of your private information (PI) held by Horizon, please complete the information below, sign in the space provided and return to Horizon, HIPAA Team, P.O. Box 1458, Newark, New Jersey 07101-1458 or via fax at 973-274-2358.

SECTION A: MEMBER INFORMATION

Name (☐ *Subscriber* ☐ *Dependent*): _____ Date of Birth: _____ / _____ / _____
MM DD YYYY

Subscriber name: _____ Horizon BCBSNJ Member ID #: _____

Address (on file): _____

City: _____ State: _____ ZIP: _____

SECTION B: DESCRIPTION OF DISCLOSURE

1. Identify the dates of service for which you are seeking records: From _____ / _____ / _____ To _____ / _____ / _____
MM DD YYYY MM DD YYYY

2. Check as applicable, or specify other information for disclosure: _____

Medical

- ☐ Claims Payment Records
- ☐ Case Management Records
- ☐ Utilization Management Records (e.g. authorization request records, appeals request records)

Mental Health/Substance Abuse

- ☐ Claims Payment Records

NOTE: for Case Management Records or Utilization Management Records (e.g. authorization request records, appeals request records) you must contact your Mental Health/Substance Abuse provider.

3. Purpose of Disclosure: _____

4. Recipient of Information: (☐ self ☐ 3rd party, If 3rd party, include name, address and phone number): _____

_____

SECTION C- DISCLOSURE OF SENSITIVE INFORMATION

I understand that Horizon BCBSNJ, its affiliates and business partners need a specific authorization to release my protected health information pertaining to the item listed below. By initialing, I authorize the release of the information pertinent to my case.

Initials		***Expiration date***
_____	HIV/AIDS	_____ / _____ / _____ MM DD YYYY

SECTION D - AUTHORIZATION FOR REQUESTED DISCLOSURE

My protected health information is specifically about me, including my name and address and/or medical information. The information was used or created when I received health care or when payment was received for my health care. The information may include my past, present or future physical or mental health or condition.

I understand that if the persons or organizations I authorize to receive and/or use the protected health information described above are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

I authorize Horizon BCBSNJ, its affiliates and business partners to disclose the above individual's protected health information. I understand that authorizing the disclosure of "protected health information" is not a condition of enrollment in Horizon BCBSNJ, of eligibility for benefits or of payment of claims. I also understand that I may revoke this authorization at any time by notifying Horizon BCBSNJ in writing. Nevertheless, this will not affect any action Horizon BCBSNJ or its affiliates and business associates take before the receipt of the notice of revocation.

This authorization will remain in effect until _____/_____/_____ or on occurrence of the following event: _____
MM DD YYYY

_____

_____ Date: _____/_____/_____
Signature of ☐ Member OR ☐ Personal Representative* MM DD YYYY

_____
Print Name

*Check one. If the requestor is other than the member, the requestor must sign the form and attach documentation showing authorization to act on behalf of the member, unless the requestor is already an established Horizon BCBSNJ personal representative with full authority.

INSTRUCTIONS
AUTHORIZATION FOR DISCLOSURE OF PRIVATE HEALTH INFORMATION

General Instructions: All fields are required to be completed unless otherwise specified.
This form must be completed to allow Horizon BCBSNJ to disclose protected health information regarding one of its members to a third party. Please know that generally, Horizon BCBSNJ does not retain protected health information for a period greater than seven (7) years, except for Medicare related records, which are retained for a period of ten (10) years. All fields are required unless otherwise specified. All required legal documents will undergo a validation process. A separate form and documentation is required for every member and for every recipient, if more than one. If you are a documented legal representative, you may make this request and sign the form on the bottom section on behalf of the member.

Section A. Member Information
This section requests information related to the member whose protected health information is being requested for disclosure. *In the name field, check to indicate if you are the subscriber or a dependent.* In the subscriber name field, write the name of the policyholder. The policy holder is the individual who holds the insurance policy with Horizon BCBSNJ.

Since the information in this section is used for verification purposes, the information must match the most current information on file at Horizon BCBSNJ. Please be aware that this form may be denied if the information on the form does not match the information in our systems.

Section B- Description of Information for Disclosure
The requested information in this section will be used by Horizon BCBSNJ to identify the specific protected health information for disclosure.

In this section, the member or requestor will identify the information for which disclosure is being authorized. Horizon BCBSNJ will provide information in accordance with our Records Management policy. In general, Horizon BCBSNJ does not retain protected health information for a period greater than seven (7) years, except for Medicare related records, which are retained for a period of ten (10) years.

Multiple selections from the Medical and/or Mental Health columns can be made, a description of the information requested can be provided, or both.

1. *Dates of service of records.* Identify the dates of service for which you are seeking these records. Provide the date of service range you are authorizing Horizon BCBSNJ to disclose. If no date range is specified, a timeframe of 18 months from the date this form was received will be utilized.

2. *Description of Information to be Disclosed.* Check the appropriate boxes for disclosure. If you are requesting the disclosure of other information not included as an option in the boxes, describe in detail the information you want Horizon BCBSNJ to disclose. You may write 'See attached description' and attach a separate sheet if necessary.

3. *Purpose of Disclosure.* Provide an explanation for the reason you want Horizon BCBSNJ to disclose the described information. Note: You may write 'See attached description' and attach a separate sheet if necessary.

4. *Recipient of Information.* Identify the entity, person or kinds of persons authorized to receive the information requested for disclosure. You must provide the name, address and phone number of the person or entity receiving the information.

Section C- Disclosure of Sensitive Information

1. This section must be completed only if you are requesting Horizon BCBSNJ to disclose information included in the provided category. You must initial on the left side of the category for disclosure and provide an expiration date.

2. This form cannot be used to request the disclosure of Mental Health/Substance Abuse Case Management Records or Utilization Management Records. For disclosures of Case Management Records or Utilization Management Records (e.g. authorization request records, appeals request records), you must contact your Mental Health/Substance Abuse provider.

Section C- *Authorization for Requested Disclosure*

You must provide an expiration date or an occurrence (ie., end of litigation, conclusion of lawsuit, etc) in which the form will no longer be valid. If this information is missing or omitted from the form the request will be deemed invalid and the request will be denied.

Mail this form to:

Horizon BCBSNJ, Attn: HIPAA Unit
PO Box 1458
Newark, NJ 07101-1458

Or Fax to: (973)274-2358

Horizon Blue Cross Blue Shield of New Jersey

Three Penn Plaza East
Newark, NJ 07105-2200
HorizonBlue.com

Notice of Nondiscrimination

Horizon Blue Cross Blue Shield of New Jersey complies with applicable Federal civil rights laws and does not discriminate against nor does it exclude people or treat them differently on the basis of race, color, gender, national origin, age, disability, pregnancy, gender identity, sex, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.

Horizon BCBSNJ provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information written in other languages.

Contacting Member Services
Please call Member Services at **1-800-355-BLUE (2583) (TTY/TDD 711) or the phone number on the back of your member ID card**, if you need the free aids and services noted above and for **all other Member Services issues, including:**

- **Claim, benefits or enrollment inquiries**
- **Lost/stolen ID cards**
- **Address changes**
- **Any other inquiry related to your benefits or health plan**

Filing a Section 1557 Grievance
If you believe that Horizon BCBSNJ has failed to provide the free communication aids and services or discriminated on the basis of race, color, gender, national origin, age or disability you can file a discrimination complaint also known as a Section 1557 Grievance. Horizon BCBSNJ's Civil Rights Coordinator can be reached by calling the Member Services number on the back of your member ID card or by writing to the following address:

Horizon BCBSNJ – Civil Rights Coordinator
PO Box 820
Newark, NJ 07101

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

Office for Civil Rights Headquarters
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019 or **1-800-537-7697** (TDD)

OCR Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

Horizon Blue Cross Blue Shield of New Jersey

If you need help understanding this Horizon Blue Cross Blue Shield of New Jersey information, you have the right to get help in your language at no cost to you. To talk to an interpreter, please call **1-800-355-BLUE (2583)** during normal business hours.

Spanish (Español): Si necesita ayuda para comprender esta información de Horizon Blue Cross Blue Shield of New Jersey, usted tiene el derecho de obtener ayuda en su idioma sin costo alguno. Para hablar con un intérprete, sírvase llamar al **1-855-477-AZUL (2985)** durante el horario normal de trabajo.

Chinese (中文)：如果您需要幫助來理解這份新澤西州地平線藍十字藍盾 (Horizon Blue Cross Blue Shield of New Jersey)資料，您有權免費獲得以您的語言提供的協助。欲聯絡翻譯人員，請於上班時間致電 **1-800-355-BLUE (2583)**。

Korean (한국어): 가입자는 Horizon Blue Cross Blue Shield of New Jersey에 관한 정보를 이해하기 위해 주로 사용하는 언어로 무료로 도움을 받을 권리가 있습니다. 통역사의 도움을 받으려면 정상 업무 시간 동안에 **1-800-355-BLUE (2583)**로 전화해 주십시오.

Portuguese (Português): Se precisar de ajuda para entender estas informações da Horizon Blue Cross Blue Shield of New Jersey, você tem o direito de receber gratuitamente assistência no seu idioma. Para falar com um intérprete, ligue para: **1-800-355-BLUE (2583)** no horário normal de trabalho.

Gujarati (ગુજરાતી): જો તમને આ ન્યુ જર્સી માહિતીનાં હોરાઈઝન્સ બ્લૂ ક્રોસ બ્લૂ શીલ્ડને સમજવા મદદની જરૂર હોય તો, તમને તમારી ભાષામાં કોઈ પણ ખર્ચ વગર મદદ મેળવવાનો અધિકાર છે. કોઈ દુભાષિયા સાથે વાત કરવા, કૃપા કરીને સામાન્ય બિઝનેસ કલાકો દરમિયાન **1-800-355-BLUE (2583)** પર ફોન કરો .

Polish (Polski): Jeżeli potrzebujesz pomocy, aby zrozumieć informacje planu Horizon Blue Cross Blue Shield of New Jersey, masz prawo poprosić o bezpłatną pomoc w języku ojczystym. Aby skorzystać z pomocy tłumacza, zadzwoń pod numer **1-800-355-BLUE (2583)** podczas normalnych godzin pracy.

Italian (Italiano): Se vi serve aiuto per capire queste informazioni della Horizon Blue Cross Blue Shield of New Jersey, avete diritto ad assistenza gratis nella vostra lingua. Per parlare con un interprete, siete pregati di telefonare al numero **1-800-355-BLUE (2583)** durante le normali ore d'ufficio.

Tagalog (Tagalog): Kung kailangan mo ng tulong sa pag-unawa nitong impormasyon ng Horizon Blue Cross Blue Shield of New Jersey, may karapatan kang humingi ng tulong sa iyong wika nang walang gastos sa iyo. Upang makipag-usap sa isang taga-interpret, mangyaring tumawag sa **1-800-355-BLUE (2583)** sa loob ng karaniwang mga oras ng negosyo.

Russian (Русский язык): Если вам необходима помощь в разъяснении этой информации, предоставленной компанией Horizon Blue Cross Blue Shield of New Jersey, у вас есть право на получение помощи на вашем родном языке бесплатно. Для связи с переводчиком звоните по номеру телефона **1-800-355-BLUE (2583)** в обычные рабочие часы.

Haitian Creole (Kreyòl ayisyen): Si ou bezwen èd pou konprann enfòmasyon sou Horizon Blue Cross Blue Shield of New Jersey, ou gen dwa pou jwenn èd nan lang natifnatal ou gratis. Pou pale avèk yon entèprèt, tanpri rele nimewo **1-800-355-BLUE (2583)** pandan lè nòmal biznis.

Hindi (हिंदी): यदि आपको न्यू जर्सी की इस होराइज़न ब्लू क्रॉस ब्लू शील्ड सूचना को समझने में सहायता की ज़रूरत है, तो आपके पास मुफ्त में अपनी भाषा में सहायता पाने का अधिकार है। किसी दुभाषिए से बात करने के लिए, कृपया सामान्य कार्य समय के दौरान **1-800-355-BLUE (2583)** पर कॉल करें।

Vietnamese (Tiếng Việt): Nếu cần được giúp đỡ để hiểu rõ thông tin này của Horizon Blue Cross Blue Shield of New Jersey, quý vị có quyền được giúp đỡ bằng ngôn ngữ của mình miễn phí. Xin gọi số **1-800-355-BLUE (2583)** trong giờ làm việc để nói chuyện với người thông dịch.

French (Français): Si vous avez besoin d’assistance pour comprendre ces informations au sujet de Horizon Blue Cross Blue Shield of New Jersey, vous avez le droit d’obtenir de l’aide dans votre langue, sans aucun frais. Pour parler avec un interprète, veuillez appeler le **1-800-355-BLUE (2583)** pendant les heures normales de bureau.

Navajo (Diné): Díí New Jersey bił hahoodzo Horizon Blue Cross Blue Shield, t’áá ninizaad k’ehjí baa hane’íí bik’i diitįįh bee shiká’ a’doowoł nínízingo éí bee ná’ahoot’i’ dóó doo bąąh ílíní da. Ata’ halne’é ła’ bich’į’ hadeesdzih nínízingo t’áá shǫǫdí **1-800-355-BLUE (2583)**jį’ nida’anishgo oolkiłíí bik’ehgo hodíílnih.

Arabic (عربي): إذا كنت بحاجة إلى المساعدة في فهم معلومات Horizon Blue Cross Blue Shield of New Jersey، لديك الحق في الحصول على المساعدة بلغتك دون تحملك أية تكلفة. للتكلم مع مترجم، يرجى الاتصال خلال ساعات العمل العادية بالرقم **1-800-355-BLUE (2583)**.

Urdu (**اردو**)**:** اگر آپ کو نیوجرسی انفارمیشن کے اس آسمانی نیلے رنگ والے تیز نیلے رنگ والے شیلڈ کو سمجھنے میں مدد کی ضرورت ہے تو، آپ کو اپنی زبان میں بغیر کسی خرچ کے مدد حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، براہ کرم، معمول کے کاروباری اوقات میں **1-800-355-BLUE (2583)** پر کال کریں۔