SSM HEALTH INSURANCE CO./SSM HEALTH PLAN/WELL FIRST HEALTH ("WELLFIRST")
AUTHORIZATION FORM
To Permit Use and Disclosure of Protected Health Information

PURPOSE OF THIS FORM: You should use this Authorization Form when you wish to give another person access to your health information. When completed, it will allow WELLFIRST to disclose your health information to the person(s) stated on this form.

SECTION A: Individual Authorizing Use and/or Disclosure

Name of Member _____ Subscriber Number _____ Date of Birth _____

Street Address _____ Telephone _____

City, State, Zip Code _____

SECTION B: The Use and or Disclosures Being Authorized

I hereby authorize the following disclosure of my protected health information as indicated below by WELLFIRST, 1277 Deming Way, Madison, WI 53717.

☐ Case Management Records ☐ Claims Correspondence ☐ Claims Payment Summary
☐ Enrollment Records ☐ Other (Specify) _____

For the following date(s) _____

Specific purpose of the use or disclosure: (check applicable categories)

☐ Assist me with all matters involving my eligibility for coverage or claims for benefits under my WELLFIRST health benefit plan.
☐ Assist me with certain matters (describe) involving my eligibility for coverage or claims for benefits under my WELLFIRST health benefit plan._____

☐ Coordination of benefits ☐ Payment of claim(s) ☐ Prior authorization
☐ Grievance ☐ Insurance eligibility/benefits ☐ Personal Reasons

To disclose protected health information to:

_____
Name of Individual/Organization

_____
Relationship to Me

_____
Street Address

_____
City, State, Zip Code

SECTION C: Individual's Signature

Right to Refuse to Sign This Authorization – I understand that I am under no obligation to sign this form and that WELLFIRST may not condition treatment, payment, or eligibility for health care benefits on my decision to sign this authorization.

Right to Withdraw This Authorization - I understand written notification is necessary to revoke this authorization. To obtain information on how to revoke my authorization, I may contact Customer Services at (800) 279-1301. I am aware that my revocation will not be effective until received by WELLFIRST and that it will not have any effect on disclosures made prior to receipt of my revocation.

Re-disclosure Notice - I understand that once WELLFIRST discloses my information based on this authorization, this information may no longer be protected by federal and state privacy standards and that my health information may be re-disclosed without obtaining my authorization.

Expiration - This authorization will expire 36 months from the date signed, unless I specify another date or event here:_____
_____

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization form, I am confirming that it accurately reflects my wishes. I am entitled to keep a copy of this form for my records.

Signature of You or Your Personal Representative: _____

Please Print Name: _____ Date: _____

If signed by a Personal Representative, please attach appropriate documentation verifying legal authority, such as Guardianship or Power of Attorney Documents.