AUTHORIZED REPRESENTATIVE DESIGNATION/REMOVAL

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Use this form to designate/remove an individual or entity to act on your behalf as your authorized representative to pursue a benefit claim or appeal of an adverse benefit determination. See your benefit plan documents or contact your plan administrator for more information. **Unless the person acting on your behalf id a Provider, you ou must also complete a Confidential Information Release Form authorizing Blue Cross® Blue Shield® of Arizona (AZ Blue) to release your confidential health information.**

NOTE: By submitting this form you agree that AZ Blue may contact you to verify the information it contains.

Member Information

Member Name		
Address		
City	State	ZIP Code
Daytime Phone Number	Email (Optional)	
Member ID	Group	

Authorized Representative Information

Member Name		
Address		
City	State	ZIP Code
Daytime Phone Number	Email (Optional)	

Choose from the following by placing an X in the appropriate boxes: (Required)

☐ **I authorize** the individual or entity shown above to act on my behalf for the following purposes:

- ☐ All claims, plan beneficiary healthcare appeals, and plan beneficiary grievances
- ☐ Other (explain)

☐ **I remove the authority** for the individual or entity shown above to act on my behalf.

ATTESTATION:

By signing below, I declare under penalty of perjury that the information contained on this form is true and correct.

Member's Signature	Date \ \
Parent or Legal Guardian (A parent or legal guardian must sign if the member is a minor.)	Date \ \

Mail completed form and Confidential Information Request Form(s) to:

AZ Blue Attention: Enrollment
P.O. Box 13466, Phoenix, AZ 85002-3466
OR Fax: **602-864-3116**
OR Email: **PrivacyOffice@azblue.com**

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