Capital BLUE

Group Health Plan Representatives Authorized to Receive Member Information Form

Name of Employer (Sponsor of Group Health Plan)	Group Number

Adding a Group Health Plan Representative(s) Authorized to Receive Protected Health Information (PHI)

Please add the following individuals to the list of authorized representatives of our group health plan effective on the date specified below. Capital BlueCross is hereby directed to disclose Protected Health Information (PHI) as requested, and as the group is eligible to receive, for plan administrative purposes. The Decision Maker and Group Administrator listed on our official group file are automatically identified as authorized group health plan representatives.

Individual (Please Print)	Organization	Date Effective

Deleting a Group Health Representative(s) Authorized to Receive Protected Health Information (PHI)

Please delete the following individuals from our list of group health plan representatives authorized to receive PHI on the date specified below:

Individual (Please Print)	Organization	Date Effective

Capital BlueCross may rely on our minimum necessary requests for the intended purpose of the disclosure of PHI and that we have received satisfactory assurance from any listed business associate to safeguard and not further use or disclose the PHI.

Capital BlueCross is entitled to rely upon this form and its directions until we revoke this letter in writing to the address noted below.

Decision Maker and/or Group Administrator Name and Title (Please Print)	
Decision Maker and/or Group Administrator Signature	**Date**

Capital BlueCross Use Only: ❒ ASO ❒ Fully Insured ❒ HRA ❒ FSA

Return this completed form to:

Group Health Plan Representative Authorization
c/o Capital BlueCross
P.O. Box 772612
Harrisburg, PA 17177-2612

PO-12 (7/2013)