AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

This form will serve as authorization for EHIM to receive your protected health information (PHI) from BCBSM and/or BCN. All family members over the age of 18 years covered under this contract must sign this form. Please indicate below your relationship to any dependent under the age of 18 years. If there are family members covered under this contract that have a different home address than the cardholder, it is acceptable for those members to sign and submit their own form. This form is for PHI authorization only. Please use another form for any other application.

Section A: PHI Authorization **Company:** ______________________ **Member ID:** ______________________

I authorize the use and disclosure of my protected health information (PHI) as described in Section B below. I understand that treatment, payment, enrollment, and eligibility will not be conditioned on whether or not I sign this authorization.

Cardholder Name		Date of Birth	**SSN**
Address			BCBSM Contract Number
City	State	Zip Code	Phone Number

Dependent Name		Date of Birth	**SSN**
Address			Relationship to Cardholder
City	State	Zip Code	Phone Number
If dependent is under the age of 18, please indicate if the Cardholder is: (circle one) Parent of Minor Child Legal Guardian Power of Attorney Executor Other:			

Dependent Name		Date of Birth	**SSN**
Address			Relationship to Cardholder
City	State	Zip Code	Phone Number
If dependent is under the age of 18, please indicate if the Cardholder is: (circle one) Parent of Minor Child Legal Guardian Power of Attorney Executor Other:			

Dependent Name		Date of Birth	**SSN**
Address			Relationship to Cardholder
City	State	Zip Code	Phone Number
If dependent is under the age of 18, please indicate if the Cardholder is: (circle one) Parent of Minor Child Legal Guardian Power of Attorney Executor Other:			

Dependent Name		Date of Birth	**SSN**
Address			Relationship to Cardholder
City	State	Zip Code	Phone Number
If dependent is under the age of 18, please indicate if the Cardholder is: (circle one) Parent of Minor Child Legal Guardian Power of Attorney Executor Other:			

Section B: PHI Use and Disclosure
This form serves as authorization for EHIM, Inc. to receive all BCBSM/BCN claims information from all healthcare providers, including but not limited to, service dates, types of service, substance abuse services, mental health services, etc. This form also serves as authorization to EHIM, Inc. to disclose claims information to BCBSM and/or BCN for the purposes of processing claims as a secondary payer.

Section C: Expiration
This form will expire when I am no longer an eligible member of the Group Health Plan or I choose to revoke this authorization. I understand that I can revoke this authorization at any time by submitting a written request to EHIM, Inc. I understand that revocation will not affect actions taken before the confirmed receipt of my request.

Section D: Member Signatures – Signatures are required for dependents over the age of 18 years.

Cardholder Signature	Print Name	Date
Dependent Signature	Print Name	Date
Dependent Signature	Print Name	Date
Dependent Signature	Print Name	Date
Dependent Signature	Print Name	Date

Please return this form to EHIM at 26711 Northwestern Hwy, Suite 400, Southfield, MI 48033.
This form may also be faxed to (248) 204-5640, attn: Eligibility Dept.