Group Plan Solutions
Benefit Administration
A Division of Pekin Insurance®

GROUP PLAN SOLUTIONS
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AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION FOR CUSTOMER SERVICE

Identifying Information for the Member:

Member ID Number:	
Member's Name:	Current Address:
Date of Birth:	Phone Number:

Names of individuals or type of individuals to whom information will be disclosed:

_____

_____

Purpose of Disclosure:

❒ For assistance in claims payment or processing

❒ Other: _____

Information to Be Disclosed:

❒ **Enrollment Information** (Includes Member Name, Member ID Number, Social Security Number, Date of Birth, Enrollment Status, Address, Home Telephone Number, Benefit Information)

❒ **Claims Payment Information** (Includes Benefit Information, Date of Service, Service Provider, Description of Services, Billing Codes, Billed Amount, Allowed Amount, Paid Amount, Claims Status, Copayments, Deductible, Coinsurance Amount on Paid Claims)

❒ **Diagnosis Information** (Includes Billing Codes, Description of the Diagnosis)

❒ **Precertification/Concurrent Review Information** (Includes Information regarding number of days authorized, information used to make determination)

❒ **Other** (Description) _____

I understand that:

1. Once Group Plan Solutions discloses information according to the Authorization, it cannot guarantee that this information will not be redisclosed to a third party or that this information will be protected by federal and state law governing the use and disclosure of identifiable health information;
2. This Authorization will remain in effect until it expires or until I provide a written notice of revocation to Group Plan Solutions;
3. I am not required to sign this authorization.

Signature of Member/Legal Representative _____

Date: _____ **Expiration Date of this Authorization:** _____

If you do not indicate an expiration date, this Authorization will expire upon termination of your coverage.