Interoperability Opt-In Authorization Form

CareFirst Family of health care plans

You may authorize your insurer, CareFirst BlueCross BlueShield ("CareFirst"), in writing to opt-in to sharing your Protected Health information with your treating provider(s) via the Provider Access API by completing and submitting this authorization.

AUTHORIZATION OF INFORMATION TO OPT IN DATA SHARING		
Name of Health Insurance Plan: ◯ CareFirst BlueCross BlueShield Medicare Advantage ◯ CareFirst BlueCross BlueShield		
Member Last Name, First Name, MI		Member ID
Mailing Address		
City	State	ZIP Code
Phone Number	Date of Birth (mm/dd/yyyy)	

DISCLOSURE
If you choose to complete this form and submit it to the CareFirst Privacy Office, you are requesting that your Protected Health information (i.e., Adjudicated Claims, Prior Authorization Status, Clinical/Encounter Data and Sensitive Data) be shared with your treating provider(s) via the Provider Access API solely for the purposes of enhancing or coordinating your care or to assist your treating provider(s) in making clinical decisions about your care. The decision to share your data with your treating provider(s) via the Provider Access API will remain in effect unless: ■ You modify your preferences and elect to Opt-out of data sharing I understand that by signing this form, I am confirming my decision to opt-in to the sharing of my Protected Health information via the Provider Access API. I also understand that this will not affect any actions taken by my health plan administrator before this request becomes effective.
Full Member Name (printed)
Signature of Member or Parent/Guardian (if applicable) / Date
This opt-in request will take effect within 60 days of receipt by CareFirst. If the person signing this form is not the member, or the parent/guardian of a dependent under the age of 18, you must attach a full copy of the official document indicating your legal authority to sign on behalf of the member (i.e., Power of Attorney, Court Assigned Guardian, Personal Representative, etc.). Please submit all written requests to the address below: CareFirst BlueCross BlueShield Privacy Office PO Box 14858 Lexington, KY 40512 Fax: 410-505-6692 Email: **Privacy.office@carefirst.com**
Please keep a record of this form. Will we provide you with a signed copy upon request.

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst BlueCross BlueShield Medicare Advantage is the shared business name of CareFirst Advantage PPO, Inc. and CareFirst Advantage DSNP, Inc. CareFirst BlueCross BlueShield Community Health Plan Maryland is the business name of CareFirst Community Partners, Inc. CareFirst BlueCross BlueShield Community Health Plan District of Columbia is the business name of Trusted Health Plan (District of Columbia), Inc. In the District of Columbia and Maryland, CareFirst MedPlus is the business name of First Care, Inc. In Virginia, CareFirst MedPlus is the business name of First Care, Inc. of Maryland (used in VA by: First Care, Inc.). CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., First Care, Inc., CareFirst Advantage PPO, Inc., CareFirst Advantage DSNP, Inc., CareFirst Community Partners, Inc., Trusted Health Plan (District of Columbia), Inc., CareFirst BlueChoice, Inc., and The Dental Network, Inc. are independent licensees of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.