Allegiance℠ by Cigna Healthcare

Authorization to Release Confidential Health and Claim Information

Follow these instructions to complete this form.
A separate form must be completed for each person age eighteen or older.

Member's personal information

Write the name of the employer plan, group number, your name, and your identification number.

Type of information to be shared

Please indicate the type of information you would like shared.

Who may receive my information

Write the name, address and relationship of the individual you are allowing to receive your information.

Purpose of disclosure

Initial each purpose that applies. If "Other" is initialed, write the purpose of the release in the blank space provided.

Note: Individuals being granted online access must be enrolled in the employer plan under the Covered Person's identification number.

Signature

To be valid, the form must be signed, dated, and notarized.

Personal representative

If you have a guardian or court appointed representative they must complete this section. They will also need to attach a copy of the legal authorization allowing them to represent the Covered Member.

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Member's personal information	
Name of Employer Plan	
Group Number	
Name of Individual Granting Authorization	
Identification Number of Covered Person	

Type of information to be shared

As the Covered Person under the above-named group health plan, I hereby authorize the Plan's claims processor ("Plan Supervisor"/ "Allegiance Benefit Plan Management, Inc.") ("hereinafter Plan Supervisor/Allegiance"), to release the following confidential health and claims-related information:

_____

_____

_____

Who may receive my information

This information may be disclosed to: _____ , at the following address, _____ , whose relationship to the Covered Person is: _____. Supervisor/Allegiance"), to release the following confidential health and claims-related information:

Purpose of disclosure

Initial	
	To determine eligibility for benefits, enrollment in a group health plan, or for underwriting determinations;
	For payment of provider claims;
	Online access of my claims information
	Other: _____

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Signature

I agree to indemnify and hold the Plan Supervisor/Allegiance harmless for confidential health and/or claims information released to the named person(s) based upon this Authorization.

This Authorization will remain valid until the Covered Person is no longer covered under the above-named group health plan and Plan Supervisor/ Allegiance no longer has any of Covered Person's information, for two years or until the following date: _____ , whichever occurs earlier.

I understand I may revoke this Authorization at any time, upon written notice to Allegiance Benefit Plan Management, Inc., P.O. Box 3018, Missoula, MT 59806, unless either: I) Plan Supervisor/Allegiance has already disclosed my confidential information in reliance upon this Authorization; or 2) this Authorization was a condition of my enrollment in the group health plan.

I understand that the Plan Supervisor/Allegiance may not condition treatment, payment of claims, enrollment in a group health plan or eligibility for benefits upon this authorization, UNLESS this Authorization is expressly for the purposes of determining eligibility for benefits, enrollment, or for underwriting or risk rating determinations.

I understand that any confidential health and/or claims information disclosed to the requesting party in accordance with this Authorization may be re-disclosed by the requesting party and at that point, would no longer be protected by this Authorization.

_____ _____

Signature of Covered Person Date

STATE OF _____

COUNTY OF _____

This Authorization was signed by _____ who provided proof of identification and who personally appeared before me, a Notary Public, this ____ day of _____ 20____.

(Seal)

_____

Signature of Notary Public

My commission expires: _____

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Personal representative

If you are a guardian or court appointed representative, you must attach a copy of your legal authorization to represent the Covered Member.

_____ _____

Signature of Covered Person's Representative Date

STATE OF _____

COUNTY OF _____

This Authorization was signed by _____ who provided proof of identification and who personally appeared before me, a Notary Public, this ____ day of _____ 20____.

(Seal)

_____

Signature of Notary Public

My commission expires: _____

Ready to send the completed form?

Please send the completed form to:

Allegiance Benefit Plan Management, Inc.
P.O. Box 3018
Missoula, MT 59806

Fax: 1-800-257-0950