Interoperability Revocation of Authorization Form

CareFirst Medicare Advantage

This form is to revoke (cancel) an authorization (permission). Completing and submitting this form allows CareFirst BlueCross BlueShield Medicare Advantage to rescind (cancel) our original authorization.

YOU MUST COMPLETE THE FOLLOWING		
Enrollee Last Name	First Name	MI
Date of Birth (mm/dd/yyyy) / /	Member/Subscriber/Enrollee ID	
Address		
Address		
City	State	Zip Code
Phone ( )		

By signing below, I understand that this revocation (cancellation) will not affect any action that the health plan or health plan administrator took before completing this revocation. Please submit all written requests to the address below:

CareFirst BlueCross BlueShield Medicare Advantage Office, PO BOX 14858, Lexington, KY 40512
Fax: 410-505-6692 Email: privacy.office@carefirst.com

ACKNOWLEDGMENT

By signing below, I understand I am confirming that my health plan or health plan administrator may no longer disclose (tell) my protected health information to:

If this request is made by a personal representative on behalf of the member, we may need to collect more information before processing your request.

Please indicate the basis of your status as a personal representative:

○ Parent or guardian of a minor ○ Active health care power of attorney ○ Court ordered guardianship of person

Enrollees: Your authorization (permission) will be revoked upon the successful submission of this form.

Personal Representatives: Your authorization (permission) will be revoked (canceled) based upon the completion of the review of additional documentation.

Enclosures: Non-Discrimination & Language Access

ACKNOWLEDGMENT (CONTINUED)

Please provide the following Personal Representative information:

Name		
Email Address	Phone Number	
Address		
Address		
City	State	Zip Code

Enrollee Name	Date
Signature	Date