BlueCross BlueShield
Federal Employee Program
1901 Market Street • Philadelphia, PA • 19103-1480

FEP CASE MANAGEMENT PROGRAM CONSENT FORM

I, _____ ID#: _____, agree to participate in the Case Management Program administered by Federal Employee Program.

I understand that this agreement to participate means that:

1. I agree to being contacted by my Federal Employee Program Health Coach.

2. I acknowledge that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Federal Employee Program may use and disclose Protected Health Information to individuals for payment, treatment and health care operations as described in my health plan's Notice of Privacy Practices. I understand that a copy of the Notice of Privacy Practices is available at www.fepblue.org/privacynotice or by request.

3. I acknowledge and agree that providers of health care services (hospital staff, physicians, therapists,etc.) will be contacted for information about me related to the development, implementation and evaluation of a Case Management Program plan of care, and for the processing of claims for the services provided under the Case Management Program.

4. I acknowledge and agree that if necessary and subject to any authorization where required, caregivers and family members will be contacted for information about me related to the development, implementation and evaluation of a Case Management Program plan of care.

5. I understand my personal health information will be disclosed for the purposes of developing, implementing and evaluating a Case Management Program plan of care for me.

6. I understand that the Case Management Program is voluntary and I may withdraw from the program at any time upon notification to Federal Employee Program.

7. I understand that my agreement to participate shall expire one year from the date of agreement entered below, upon the termination of my health insurance coverage (for whatever reason) or discharge from the Case Management Program, whichever is sooner.

8. I understand that I should retain a copy of this document for my records and that a photocopy of this document is as valid as the original.

9. I have read the above (or the above has been explained to me) and I hereby agree to participate in the Case Management Program of Federal Employee Program.

AGREED TO AND ACCEPTED BY:

Member Name: (please print) _____
I agree you may contact me (the member) at this number: _____
Signature of Member, Guardian or Power of Attorney: _____
Name of Guardian or Power of Attorney: (please print) _____
Relationship to Member: _____ Telephone: (____)_____ Date:_____

If the member is physically unable to sign this authorization, the witnesses who have signed below are acknowledging that they witnessed the member freely give his/her verbal consent and the member understood.

AGREED TO AND ACCEPTED BY:
Member Name: (please print) _____

Signature of Member, Guardian or Power of Attorney: _____

Name of Guardian or Power of Attorney: (please print) _____

Relationship to Member: _____ Telephone: (____)_____Date:_____

If the member is physically unable to sign this authorization, the witnesses who have signed below are acknowledging that they witnessed the member freely give his/her verbal consent and the member understood.

Witness _____ Witness_____
Date: _____ Date: _____