Excellus

An independent licensee of the Blue Cross Blue Shield Association

Frequently Asked Questions about Consent to Case Management Paperwork

Why do I need to sign this paperwork?
You are being asked to sign this form because we previously received notice, either directly from you or from your healthcare provider, that you revoked your permission for us to share or use your substance use disorder (SUD)-related information. To provide you with case management services, we may need to review, use, and share certain health information so we can coordinate your care, support your providers, and help you get the services you need. Because of your earlier revocation, we cannot do this unless you give us permission.

What if my child is the one receiving treatment?
If your child is less than 18 years old, your child will need to sign this paperwork to consent because state and federal regulations require the individual to consent to their own care regardless of their age. It also means your child will need to give you permission to access their diagnosis or treatment information.

How can my child give me permission to see their information?
It's important to understand that it is your child's choice about whether they give permission for you or anyone else to see their case management information. Your child's decision does not affect the care they receive.

- Your child will need to fill out the Authorization to Disclose Protected Health Information (PHI) form before information can be released to you or anyone else. Search for "Manage your Privacy" at www.excellusbcbs.com to find the form.

Is there anything else I need to know about the Substance Use Disorder Regulation?
Pursuant to 42 CFR Part 2, any substance use disorder information from a Part 2 Program relating to these case management services will only be used or released in accordance with a written consent to release, or as permitted under applicable law(s), and members have a right to obtain a list of disclosures as described in Section II, Part D below.

PLEASE RETURN THE COMPLETED FORM TO:

Excellus BlueCross BlueShield
P.O. Box 21146
Eagan, MN 55121
Or Fax: 1-877-243-6819

PLEASE MAKE A COPY OF THIS FORM FOR YOUR RECORDS

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PO Box 21146
Eagan, MN 55121

For Internal Use

CASE MANAGEMENT PROGRAM CONSENT

Member Information:			
Last Name	First Name	MI	Date of Birth
Current Address	City	State/Zip Code	Phone Number
Identification # - located on ID card(s)			

Section I: Case Management Consent

I agree to participate in the case management program administered by Excellus BlueCross BlueShield or its contracted agency (Health Plan), including services that address substance use disorder (SUD). This is a collaborative process between myself, my Health Plan care manager and my health care team. Case management services may include general health education, coordination of care with my health care team, and referrals to appropriate community resources.

By agreeing to participate and by signing below:

1. I consent to and agree that I can be contacted by telephone at the number(s) provided, in writing, or in person by the Health Plan care manager(s) for case management of my health condition(s).
2. I understand that:
    - The case management program is voluntary, except where otherwise required under my contract benefits, and when voluntary, I may withdraw from the program at any time by notifying the Health Plan either verbally or in writing.
    - This consent to case management is not a condition for receiving care or treatment by my physician or coverage by the health plan, except where otherwise required under my contract benefits.
    - This consent is to remain in effect as long as I remain in the case management program. I can revoke this consent at any time by notifying the Health Plan either verbally or in writing (when required), except this revocation would not affect any action taken by the Health Plan in reliance on this consent before my revocation is received.
    - I will follow the contractual provisions of my health insurance contract and the case management program policies and guidelines of the Health Plan.
    - As permissible under state and federal laws, the Health Plan may use my personal health information (PHI) in its possession to help provide case management resources and services to me.
    - Any information I share as part of the Health Plan's case management program can be shared with any other entity that is involved in and helps manage my care.
3. If the case management program I am receiving includes the option for in-person meetings, I understand that choosing to meet in a public location (such as a coffee shop, library or shared household) may involve privacy risks. I acknowledge that individuals in these settings may overhear conversations related to my health information.

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Section II: Consent to Release of Substance Use Information

Part A: PERSON(S) PERMITTED TO MAKE DISCLOSURES

1. Excellus BlueCross BlueShield (“Health Plan”).
2. Any health care provider that has treated me in the past, is treating me now, or treats me in the future (“Provider”).

Part B: RECIPIENT OF AND PURPOSE OF DISCLOSURE

1. Provider may disclose Patient Identifying Information (PII) to Health Plan to conduct case management and care-coordination activities.
2. Health Plan may disclose PII to Provider for case management and care coordination activities.
3. Health Plan may disclose PII to other third parties involved in your case management or care-coordination activities, as permitted under applicable laws.

Part C: INFORMATION TO BE DISCLOSED

All information necessary for case management and care coordination of substance use disorder(s). This may include (among other information) diagnoses (names of illnesses or conditions), procedures (type of treatments), dates of treatment, and names of health care practitioners or other providers.

Part D: DISCLOSURE ACCOUNTING

Health Plan is required to provide you (or your authorized representative) with a list of the persons or entities to whom the Health Plan has re-disclosed your Patient Identifying Information pursuant to this consent, in accordance with the requirements of the Confidentiality of Substance Use Disorder Patient Records Rule (42 CFR Part 2). The list may be limited to disclosures made within the three years immediately preceding the date of your request. You may request a list of disclosures in writing. Request can be sent to: Corporate Privacy Office, P.O. Box 4809, Syracuse, NY 13221-9987.

Part E: EXPIRATION OR REVOCATION OF CONSENT

This consent for disclosure will expire one-year after you disenroll from the Health Plan. You may revoke this consent at any time by writing the Health Plan at the address provided below. Your revocation will not be effective, however, to the extent that Health Plan, or any Provider has acted in reliance on the consent.

Section III: ACKNOWLEDGEMENT (PLEASE READ AND SIGN)

IMPORTANT: I have read the contents of this form. I hereby consent to participate in the case management program administered by the Health Plan for substance use disorder. I agree to allow the disclosures of my information as described above.

Signature: _____ **Date:** _____

If this request is from a personal representative on behalf of the member, complete the following:

Personal Representative’s Name: _____

Personal Representative Signature: _____ Date: _____

Description of Authority: ☐ Parent ☐ Legal Guardian* ☐ Power of Attorney*

☐ Other * _____

* You must provide documentation supporting your legal authority to act on behalf of the member