BlueCross BlueShield of Montana

RESTRICTION REQUEST FORM

Use this form to request restrictions on Blue Cross and Blue Shield of Montana's use or disclosure of your Protected Health Information for treatment, payment, or health care operations purposes as well as for a disclosure of your PHI to a family member, relative or others involved in your care. This form can also be used to terminate a previously granted request for restriction. You must complete all the fields on this form.

DO NOT USE THIS FORM TO REQUEST A CHANGE OF ADDRESS.
If you need assistance in completing this form, or with a change of address, please call the Customer Service number listed on your Member Identification Card.

WHEN COMPLETED AND SIGNED PLEASE MAIL TO:
Blue Cross and Blue Shield of Montana
PO Box 660044
Dallas, TX 75266-0044
OCA_SSD@bcbstx.com

Section A Restriction Request or Termination

Is this form being used to terminate a previously approved request for Restriction? If "Yes", complete Section B, then proceed to Section D. If "No", then complete the form entirely.

☐ Yes Enter date to terminate previous request (month/day/year): _____

☐ No

Section B The individual for whom restriction is being requested. Please complete the following:

First Name _____ Last Name _____ Group Number _____

Social Security Number _____ Date of Birth _____ Identification\Subscriber Number _____

Address _____ City _____ State _____ Zip _____

Area Code & Telephone Number _____ E-mail Address (if available) _____

Section C Please specify your PHI that you want restricted:

_____
_____
_____
_____

Please state how you would like to restrict the use and disclosure of this information:

_____
_____
_____
_____

Please indicate if this restriction request should apply to communicating your PHI to your Health Savings Account or Flexible Savings Account, if applicable:

☐ Yes ☐ No

BlueCross BlueShield of Montana

If your request is granted, please make note of the following:

1. The request only applies to your current coverage. If any of the information about your coverage changes including Group or Subscriber number, benefit coverage changes (i.e., dental coverage is added), you must submit a new Restriction Request.
2. The request will expire eighteen (18) months after your benefits coverage has terminated.
3. Blue Cross and Blue Shield of Montana and its Business Associates are only responsible for the PHI designated in Section C.

Section D Signature: This document must be signed by the individual, parent of minor child or the individual's Personal Representative.

I request that Blue Cross and Blue Shield of Montana restrict the use or disclosure of my PHI as specified in Section C above. I understand that Blue Cross and Blue Shield of Montana is under no obligation to agree to my request. I understand I will receive a written determination regarding my request. I understand that if I am signing on behalf of a minor child, this request will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

Signature _____ Date: month/day/year _____

Section E If Section D is signed by a Personal Representative, please complete the information below:

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator, please attach a copy of the legal documents. You do **NOT** have to attach copies of these documents if they are already on file with Blue Cross and Blue Shield of Montana.

Personal Representative's Name _____ Relationship to Individual _____

Personal Representative's Address _____ City _____ State _____ Zip _____

Personal Representative's Area Code & Telephone Number _____

Personal Representative's E-mail Address (if available) _____

Any changes to the format, content or branding of this form are strictly prohibited without review and approval of the Privacy Office.