Law Enforcement Health Benefits, Inc.

2233 Spring Garden Street, Philadelphia, PA 19130 (215) 763-8290

This form MUST be returned EVERY year!

1 DATE:

2 NAME and ADDRESS:

3 Soc. Sec.#:

4 Payroll #:

5 Blue Cross #:

LEHB ANNUAL COORDINATION of BENEFITS Form 2018

Please review this information. Cross out anything that is incorrect, and write in corrections.
Please include any new or updated medical, or dental/optical/prescription, insurance coverage.

RETURN FORM WITHIN 15 DAYS - or payment of your claims will be delayed.

6 ***Verify Dependents:*** **Medical Coverage:**

Name	Soc Sec#	Birth Date	Other Coverage	ID Number	Effective	Term Date

7 **Dental, Optical, Prescription Coverage:** *(other than FOP-DOP coverage)*

Name	Soc Sec#	Birth Date	Other Coverage	ID Number	Effective	Term Date

I certify that the above information is true and correct. ***(Member's Signature Required ON BOTH SIDES of form)***

Signature: _____ Date: _____ E-Mail: _____

8 **This annual form expires on December 31, 2018**

Authorization to Release Information please print

This form is used to release your protected health information as required by federal and state privacy laws. Your authorization allows the Health Plan (your health insurance carrier or HMO) to release your protected health information to a person or organization that you choose. You can revoke this authorization at any time by submitting a request in writing to the Health Plan (contact Member Services for further instructions). Revoking this authorization will not affect any action taken prior to receipt of your written request.

Section A: Member Information: (individual whose information will be released)

Name: (First, Middle, Last, Title)	**Member ID Number**	**Date of Birth:** (Month/Day/Year)
9		
Address: (including zip code)		**Telephone Number:** (including area code)
,		

Section B: Health Plan: (organization that will release your information)

I authorize INDEPENDENCE BLUE CROSS and MAGELLAN to release my protected health information as described below.
(Health Plan name on your ID card)

Section C: Recipient: (person or organization that will receive your information

Person's Name or Organization:	**Telephone Number:** (including area code)
LAW ENFORCEMENT HEALTH BENEFITS, INC.	(215) 763-8290
Address: (including zip code)	**Fax Number:** (including area code)
2233 SPRING GARDEN ST, PHILADELPHIA, PA 19130	(215) 763-8808

Section D: Description of Information to be released: (what type of information will be released)

Check only one box:

☐ **Psycotherapy notes** - Federal law requires an authorization to use or release psychotherapy notes.
If you check this box, you may not check another box below.

☒ **All information related to the provision of and payment for my health care benefits or services, including coordination of care and case management services.***

☐ **Specific information described below:**

_____
Examples: The claim related to my service on (date); Appeal information related to my claim on (date)

***NOTE:** State law requires that you give specific permission to release the information below even if you checked a box above. Indicate your permission for the Health Plan to release any of the following information by initialing all that apply.

Genetic Information _____ (Initials) **HIV/AIDS** _____ (Initials)

Substance/Alcohol Abuse 10 _____ (Initials) **Mental/Behavioral Health** 11 _____ (Initials)

Purpose of Release: At my request
Examples: At my request; To resolve my appeal; To assist with my health insurances services.

Section E: Expiration: (when this authorization will end)**

This authorization will expire (Check ONLY ONE box):

☐ **When I revoke this authorization ***

☒ **Upon the following date, event or condition *:** Until I revoke this authorization in writing, or until my medical benefits expire.

Note: This authorization will terminate on the earliest of the events listed above or 180 days after termination of coverage.

* The party identified in section B must be notified in writing of the event/condition to cancel or revoke this authorization.

** Please note: State law requires that this Authorization to Release Information will automatically expire in 12 months for Minnesota residents and in 24 months for Montana residents unless you specify a shorter timeframe.

Section F: Approval: (You OR your Personal Representative must sign and date this form in order for it to be complete.)

I understand that this authorization to release information is voluntary and is not a condition of enrollment in this Health Plan, eligibility for benefits, or payment of claims. I also understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, they may further release the protected health information and it may no longer be protected by federal privacy laws.

Member Signature:
By signing below, I authorize the release of my protected health information as described above.

12 _____ (Print Name)

_____ (Signature of Member)

_____ (Date)

Personal Representative Information:
A personal representative is a person who has the legal authority to act on the behalf of an individual. A copy of a Power of Attorney or other legal document must be on file at the Health Plan or submitted with this form.

_____ (Printed name of Personal Representative) _____ (Description of Representative's authority)

_____ (Date) _____ (Signature of Personal Representative) ( ) _____ (Telephone Number)

PLEASE KEEP A COPY OF THIS FORM AND THE INSTRUCTIONS FOR YOUR RECORDS

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OVER

COB FORM INSTRUCTIONS

This form must be filled out completely.

If any fields are blank or incomplete, the form will be returned.

1. Enter today's DATE
2. Enter NAME and ADDRESS:
3. Enter SOCIAL SECURITY Number
4. Enter PAYROLL Number
5. Enter BLUE CROSS Number (if available)
6. For YOURSELF and ALL COVERED dependents enter:

    Name
    Social Security Number
    Birth Date
    If there is ANY OTHER MEDICAL COVERAGE enter:
        Name of ANY OTHER medical coverage
        ID Number of other medical coverage
        Effective Date of other medical coverage
        Termination Date of other medical coverage

7. For YOURSELF and ALL COVERED dependents if there is ANY OTHER DENTAL, OPTICAL, or PRESCRIPTION coverage enter:

    Name
    Social Security Number
    Birth Date
        Name of ANY OTHER insurance coverage
        ID Number of other insurance coverage
        Effective Date of other insurance coverage
        Termination Date of other insurance coverage

8. SIGN and DATE the form. The form MUST be signed or it will be returned:

AUTHORIZATION FORM INSTRUCTIONS

By signing the form you allow LEHB to act on your behalf.

9. Enter NAME, ADDRESS, BIRTH DATE, and TELEPHONE NUMBER
10. To enable LEHB to discuss Substance/Alcohol Abuse information with a provider you must initial this line.
11. To enable LEHB to discuss Mental/Behavioral Health information with a provider you must initial this line.
12. PRINT your name, and SIGN and DATE the form. The form MUST be signed or it will be RETURNED.