



PEKIN LIFE INSURANCE COMPANY

2505 Court Street Pekin, Illinois
800/322-0160 Fax: 309/346-8265
www.pekininsurance.com

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION FOR CUSTOMER SERVICE

Identifying Information for the Insured:

Insurance ID Number:	
Insured's Name:	Current Address:
Date of Birth:	Phone Number:

Names of individuals or type of individuals to whom information will be disclosed:

Purpose of Disclosure:

- For assistance in claims payment or processing
- Other: _____

Information to Be Disclosed:

- Enrollment Information** (Includes Member Name, Policy Number, Social Security Number, Date of Birth, Enrollment Status, Address, Home Telephone Number, Benefit Information)
- Claims Payment Information** (Includes Benefit Information, Date of Service, Service Provider, Description of Services, Billing Codes, Billed Amount, Allowed Amount, Paid Amount, Claims Status, Copayments, Deductible, Coinsurance Amount on Paid Claims)
- Diagnosis Information** (Includes Billing Codes, Description of the Diagnosis)
- Precertification/Concurrent Review Information** (Includes Information regarding number of days authorized, information used to make determination)
- Other** (Description) _____

I understand that:

1. Once Pekin Life Insurance Company discloses information according to the Authorization, it cannot guarantee that this information will not be redisclosed to a third party or that this information will be protected by federal and state law governing the use and disclosure of identifiable health information;
2. This Authorization will remain in effect until it expires or until I provide a written notice of revocation to Pekin Life Insurance Company;
3. I am not required to sign this authorization.

Signature of Insured/Legal Representative _____

Date: _____ **Expiration Date of this Authorization:** _____

If you do not indicate an expiration date, this Authorization will expire upon termination of your coverage.