Reset

Group Plan Solutions
Benefit Administration
A Division of Pekin Insurance®

GROUP PLAN SOLUTIONS
PO Box 1587 • Pekin, Illinois 61555-1587
www.groupplansolutions.com
(888) 301-0747 • Fax: (855) 545-7165

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION FOR CUSTOMER SERVICE

Identifying Information for the Member (Any member age 18 or older will be required to complete their own authorization):

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

***The following information is required:**
*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, Member ID 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 Group Plan Solutions 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 Group Plan Solutions;
3. I am not required to sign this authorization.

***Signature of Member/Legal Representative** _____

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

You may return this form to our office via mail or fax to (855) 545-7165.

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