BlueCross BlueShield
Federal Employee Program

CONSENT FOR CASE MANAGEMENT

CASE MANAGEMENT AGREEMENT FORM AND RELEASE OF MEDICAL INFORMATION

I,_____, as a member or authorized representative of the member, agree to participate in the Case Management Program offered by Blue Cross Blue Shield of Rhode Island.

I understand that this means:

1. My case manager may contact me and/or my care team to discuss my healthcare needs. My care team includes my authorized representative and healthcare providers (hospital staff, doctors, therapist, etc.).

2. By my signature below, I authorize the release of medical information by my case manager. The information will be used to create, update and review my care plan.

3. My health plan offers case management at no additional cost to me. It's my choice to participate.

4. If I want to leave the program at any time, I can contact my case manager. I will still receive my benefits outlined in the Blue Cross and Blue Shield Service Benefit Plan brochure (RI 71-005) after my case management services end.

5. I understand that some benefits require I participate in case management. I also understand leaving the case management program will mean services requiring case management participation will no longer be covered.

6. I must follow the program requirements outlined in section 5(h) of the Service Benefit Plan brochure.

You should keep a copy of this document for your records. A copy of this form is as valid as the original.

This agreement is active for one year from the date signed, or when I am no longer a member of the Blue Cross and Blue Shield Service Benefit Plan.

_____ _____

Member Name ID

_____ _____ _____

Signature Relationship to Member Date

"I agree you may contact me at this number: _____"