HIPAA Request Form

This authorizes Paragon Benefits to discuss with and provide to _____ any information he or she may request concerning the status of claims, including payment information, copies of explanations of benefits, and information concerning the handling or filing of any claims. This information is to be provided for the purpose of facilitating, investigating or tracking determinations of medical necessity, prior authorization, approval, denial and/or payment of claims for medical expenses.

This authorization is effective _____, 20__, and will continue in effect until it is rescinded by me, in writing. I understand that I have the right to revoke this authorization in writing at any time, except to the extent that Paragon Benefits has already relied upon it. My authorization is voluntary, and refusing to sign will not affect my ability to obtain treatment or eligibility for benefits. I also understand that any information provided to the person named above will no longer be protected by federal privacy laws.

_____ _____

Signature of Insured Member ID

_____

Signature of Spouse/Dependent

_____

Date Signed

ParagOn

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