AUTHORIZATION FORM

WellFirst Health® WellFirst Health® provided by SSM Health Plan

To Permit Use and Disclosure of Protected Health Information

Purpose of this Form: You should use this Authorization Form when you wish to give another individual or organization access to your health information. When completed, it will allow WellFirst Health or WellFirst Health — Provided by SSM Health Plan to disclose your health information to the individual/organization stated on this form.

Section A: Individual Authorizing Use and/or Disclosure

Member Name _____ Subscriber Number _____

Member Date of Birth _____ Telephone Number _____

Street Address _____

City _____ State _____ Zip Code _____

Section B: The Use and/or Disclosures Being Authorized

I hereby authorize the following disclosure of my protected health information as indicated below by WellFirst Health or WellFirst Health — Provided by SSM Health Plan - 1277 Deming Way, Madison, WI 53717 (check applicable document types):

☐ Case Management Records ☐ Claims Correspondence ☐ Claims Payment Summary

☐ Enrollment Records ☐ Other (Specify) _____

For the following date(s) _____

Specific purpose of the use or disclosure (check applicable categories):

☐ Assist me with all matters involving my eligibility for coverage or claims for benefits under my WellFirst Health or WellFirst Health — Provided by SSM Health Plan benefit plan.

☐ Assist me with certain matters (describe) involving my eligibility for coverage or claims for benefits under my WellFirst Health or WellFirst Health — Provided by SSM Health Plan benefit plan.

☐ Coordination of benefits ☐ Payment of claim(s) ☐ Prior authorization

☐ Grievance ☐ Insurance eligibility/benefits ☐ Personal reasons

Disclosure to:

Name of Individual/Organization | Relationship to Me

Street Address

City | State | Zip Code

Section C: Individual's Signature

Right to Refuse to Sign This Authorization – I understand that I am under no obligation to sign this form and that WellFirst Health or WellFirst Health — Provided by SSM Health Plan may not condition treatment, payment, or eligibility for health care benefits on my decision to sign this authorization.

Right to Withdraw This Authorization – I understand written notification is necessary to revoke this authorization. To obtain information on how to revoke my authorization, I may contact the Customer Call Center at 1-800-279-1301. I am aware that my revocation will not be effective until it is received by WellFirst Health or WellFirst Health — Provided by SSM Health Plan and that it will not have any effect on disclosures made prior to receipt of my revocation.

Re-disclosure Notice – I understand that once WellFirst Heath or WellFirst Health — Provided by SSM Health Plan discloses my information based on this Authorization Form, this information may no longer be protected by federal and state privacy standards and that my health information may be re-disclosed without obtaining my authorization.

This authorization will expire 36 months from the date signed, unless I specify another date or event here:

I have had an opportunity to review and understand the content of this Authorization Form. By signing this Authorization Form, I am confirming that it accurately reflects my wishes. I am entitled to keep a copy of this form for my records.

Member Signature or Member's Personal Representative

Printed Name | Date

WellFirst Health products are underwritten by SSM Health Insurance Company, provided by SSM Health Plan or administered by Dean Health Service Company.