

WELLCHOICE

AUTHORIZATION FOR RELEASE OF INFORMATION

SUBSCRIBER'S/PATIENT NAME: _____

SUBSCRIBER'S/PATIENT'S *WELLCHOICE*
IDENTIFICATION NUMBER: _____

I do hereby affirm that I am the above mentioned subscriber/patient or legally authorized representative of the above-mentioned subscriber/patient. I hereby Authorize *WELLCHOICE* to release claims, payment, eligibility, and benefit information to my representative, _____
(Please print name of authorized representative)

and to allow my representative to update my address and/or primary care physician change (if applicable). This authorization is valid from the date signed until:

(enter date)

Indefinitely

Limitations: _____

Signature of Subscriber/Patient
Date

Date

Signature of Representative