

XSI and Claims Direct Access

AUTHORIZATION FOR CLAIM PROCESSING PURPOSES
Pursuant to the HIPAA Privacy Rule ~164.508(c)

I, the undersigned, authorize any licensed physician, medical practitioner, hospital, clinic, medical or medical related facility, the Veteran's Administration, insurance company, the Medical Information Bureau, Inc. (MIB), employer, or Government agency to disclose personal information about me as described below .

This authorization was prepared by XSI for the purposes of obtaining personal information necessary to process a claim for benefits. The information subject tot his authorization is any and all information including health information, requested by XSI or Claims Direct Access for the purpose stated above as well as any information provided to them or their affiliated insurance companies on any previous applications. The information covered by this authorization does not include psychotherapy notes but does include any information about drug abuse, alcoholism, and mental illness. In addition, the information covered by this authorization does include any such information that has been restricted by my request.

Persons or entities employed by or authorized by XSI and Claims Access Direct to perform tasks related to the claims process are hereby authorized to use the personal information covered by this authorization. I understand that if this person or entity that receives this information is not a health care provider or health plan covered by federal privacy regulations, the information may no longer be protected by federal privacy regulations and may be subject to re-disclosure. However, I further understand that all such persons or entities have signed agreements to protect said information.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by XSI or Claims Direct Access or so long as XSI or Claims Direct Access has a legal right to contest the coverage or a claim under the coverage. Revocation requests must be sent in writing to:

ATTN: Claims Processing
XSI
P.O. Box 1078
Draper, UT 84020

I understand that XSI or Claims Direct Access cannot condition the payment of a claim on my signing this authorization. This authorization will expire upon the final action related to the claim for which this authorization is signed.

A copy of this authorization may be used in place of the original. If this authorization is for someone other than myself, that individual and my authority to act on his/her behalf are explained below.

(Please Print) Name of Individual Whose Information is covered by This Authorization

Signature of the Individual

Date

Name of Legal Representative and Relationship to Individual

Signature of Representative

Date