HIPAA AUTHORIZATION
CLAIM INFORMATION FORM

Please fax this document, along with **the completed and signed authorization letter** to

Propel Insurance
Fax (253) 759-8217

Please provide the following information:

1) **Employer:** _____
2) **Employee Name (Subscriber):** _____
3) **Employee I.D. Number (SS#):** _____
4) **Employee Date of Birth:** _____
5) **Patient Name:** _____
6) **Phone Number:** _____
7) **Email Address:** _____
8) **Date of Service:** _____
9) **Providers Name & Phone Number:**_____
10) **Please explain the situation:**
    _____
    _____
    _____
    _____
    _____
11) **Please attach a copy of provider's office billing or your explanation of benefits from your insurance carrier if you have one.**

If you have any questions while completing this form, please contact Propel Insurance at (800) 499-0933.

AUTHORIZATION

At the request of the undersigned, Propel Insurance is hereby authorized to act on my behalf to assist in the processing of claims and/or resolving issues relating to the payment of claims for health/dental care services rendered during the period _____ to _____.

I am aware that in order to provide the service described above, health/dental information contained in or related to my health care records during the time period identified above may be disclosed to the health/dental care carrier/insurer. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the health care carrier/insurer and may no longer be protected by the Health Insurance Portability and Accountability Act, codified under 45 CFR 160 *et seq.*

I understand that treatment, payment, enrollment, or eligibility for benefits are not conditioned on my signing of this Authorization. I have elected to sign this Authorization voluntarily.

This Authorization is valid through the period identified above. I acknowledge that I have the right to revoke this Authorization in writing, except to the extent Propel Insurance has taken action in reliance on this Authorization. Any written notice of revocation of this Authorization must be sent via first-class mail, postage pre-paid to:

Propel Insurance
Attn: Employee Benefits Division
1201 Pacific Ave., Suite 1000
P.O. Box 2940
Tacoma, Washington 98401-2940

Dated: _____ Name: _____

Social Security #: _____

Signature: _____