



1 Cameron Hill Circle  
Chattanooga, TN 37402  
bcbstmedicare.com

## Request for Personal Representative

A Personal Representative is someone you appoint to communicate with us on your behalf.

Instructions: To ask for a Personal Representative, please fill out the information below, sign and return by mail or fax to:

**BlueCross BlueShield of Tennessee**  
**BlueAdvantage Operations**  
**1 Cameron Hill Circle, Suite 0005**  
**Chattanooga, TN 37402-0005**  
**Fax: (423) 535-5498**

**Please print clearly.**

☐ New Request ☐ Change Request

### Member Information:

Subscriber Name: \_\_\_\_\_

Member ID #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Telephone #: (\_\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I, \_\_\_\_\_, hereby appoint \_\_\_\_\_ to be  
**(NAME)** **(PERSONAL REPRESENTATIVE)**

designated as my personal representative. I understand this request applies to communications from BlueCross BlueShield of Tennessee and its business associates about my private information. I also understand that mental health and/or substance abuse private information may be disclosed if I have utilized such services.

NOTE: This request will stay in effect until the member or his/her legal representative notifies BlueCross BlueShield in writing asking for a change.

**Representative Information: (required for privacy verification purposes)**

Name (Last, First, MI): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone #: (\_\_\_\_\_) \_\_\_\_\_ Relationship to the member: \_\_\_\_\_

Email: \_\_\_\_\_

NOTE: If the representative is court ordered or has another legal designation (examples: power of attorney, living will, executor or administrator of probate estate), you must attach/include a copy of the official document(s) if not already supplied. If you are a documented legal representative, you may make this request and sign this form below for the member.

Signature of Member / Requestor: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date : \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
          **MM**      **DD**      **YYYY**

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Note: Email communications are not secure, so there is a possibility that information included in emails can be intercepted or read by someone else. By providing your email address, you accept the risks associated with emailing.

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