BlueCross BlueShield of Alabama

An independent licensee of the Blue Cross Blue Shield Association

DISCLOSURES TO OTHER BUSINESS ASSOCIATES AND THIRD PARTY ADMINISTRATORS OF THE PLANS(S)

Please complete this form and provide us the names of the other business associates and third party administrators of your group health plan(s) (such as, benefit consultants or pharmacy benefit managers) to whom wyou (on behalf of the plan(s)) want us to disclose protected health information. Also list any conditions or limitations that apply to our disclosure of protected health information to them. If you list no conditions or limitations, then we will disclose to the listed business associates and third party administrators all of the requested protected health information that would be available to your plan(s).

The undersigned hereby authorizes Blue Cross and Blue Shield of Alabama, as Business Associate, to disclose protected health information to the following business associates and third party administrators:

TPA Name	Condition/Limitation
JH Berry Risk Services	None
Springbuk	None
ABS	None

The undersigned hereby agrees to notify Blue Cross and Blue Shield of Alabama of any changes to this list of business associates and third party administrators.

Executed this:	Day of	Year	

For the Plan(s):

Group Health Plan *Insert Company name*	**Group Number(s)**

Signed:	Printed/eSignature:

Title:

If you have more than one group health plan or need more space to identify additional business associates, please copy this form as needed. If you do not return this form, then we will not disclose protected health information to the other business associates and third party administrators of the plan(s) until the plan(s) authorize us to do so in writing.

Please complete, sign and return this form to:

Blue Cross and Blue Shield of Alabama
Attention: Enrollment Services
Fax: 205-220-9902 or Email your designated Enrollment Service Representative.