BlueCross BlueShield
Federal Employee Program

Independence

1901 Market Street
Philadelphia, PA 19103-1480

CONSENT FOR CASE MANAGEMENT

CASE MANAGEMENT AGREEMENT FORM

I, _____, as a member or authorized representative of the member, agree to participate in the Case Management Program offered by Independence Blue Cross (Independence).

I understand that this means:

1. My case manager may contact me and/or my care team to discuss my health care needs. My care team includes my authorized representative and health care providers (e.g., hospital staff, doctors, therapist).
2. My case manager may give my care team and health plan my medical information in order to create, update, and review my care plan. It will also help my health plan process my claims correctly.
3. My health plan offers case management at no additional cost to me. It's my choice to participate. I will still receive my regular health plan benefits regardless of my choice to participate in the program.
4. If I want to leave the program at any time, I can contact my case manager. I will still receive my benefits outlined in the Blue Cross and Blue Shield Service Benefit Plan brochure (RI 71-005) after my case management services end.
5. As part of my care plan, my health plan may offer me "alternative benefits." These are services that my health plan does not normally cover but could help me achieve my health goals.

   If my case manager at Independence approves alternative benefits for me, I must:

   - sign an Alternative Benefits Agreement and follow the guidelines listed in the agreement;
   - actively participate in the Case Management Program until my official program end date.

   Independence may change the decision to offer me an alternative benefit at any time. The U.S. Office of Personnel Management cannot review this decision through the disputed claims process.
6. I must follow the program requirements outlined in section 5(h) of the Service Benefit Plan brochure. I must also follow the guidelines provided by my case manager.

Please keep a copy of this document for your records. A copy of this form is as valid as the original.

This agreement is active for one year from the date signed or until I am no longer a member of the Blue Cross and Blue Shield Service Benefit Plan.

_____ _____

Member name Member ID #

_____ _____

Family representative and relationship to patient Date