Instruction page crosswalk

NEW FORM	OLD FORM
Added title - Medicare Authorization to Disclose Personal Health Information (CMS-10106; OMB# 0938-0930)	N/A
Section 1 - no change	
Section 2 This section tells Medicare what personal health information to give out. Please check either 2A or 2B in Section 2 to indicate how much information Medicare can disclose. Check Box 2A if you want Medicare to release any information. Check Box 2B if you only want Medicare to give out limited information (for example, Medicare eligibility).You must select the type of information you want Medicare to give out by checking the circle(s) under 2B. Box 2C must be completed by **New York Residents. Please see instructions below for completing section 2C.** **Instructions for NY Residents completing Section 2C of the Authorization Form:** *Please select one of the following options on the form to authorize Medicare to release the following information.* · **Check box (a) –** If you select box a, Medicare will release all information. This will include information about alcohol and drug abuse, mental health treatment, and HIV. · **Check box (b) –** If you select box b, Medicare will NOT release any about alcohol and drug abuse, mental health treatment and HIV.	This section tells Medicare what personal health information to give out. Please check a box in 2a to indicate how much information Medicare can disclose. If you only want Medicare to give out limited information (for example, Medicare eligibility), also check the box (es) in 2b that apply to the type of information you want Medicare to give out.

You should only check a OR b. Do not select both.	
Section 3 This section tells Medicare when to start and/or when to stop giving out your personal health information. Check the first box (a) if you do not want to limit the timeframe, for which Medicare can give out your information, OR Check the second box (b) and fill in dates if you want Medicare to only give out information for specific time. You MUST provide a start and stop date if selecting box (b). You should only check a or b. Do not select both.	3. This section tells Medicare when to start and/or when to stop giving out your personal health information. Check the first box if you don't' want to limit the time frame for which Medicare can give out your information, or check the second box and fill in dates if you want Medicare to only give out information for specific time.
Section 4 - no change	
Section 5 The person with Medicare must sign his/her name, fill in the date, and provide the phone number and address of the person with Medicare. If you are the personal representative for the person with Medicare, you must complete section 5 for the beneficiary and complete section 6.	5. The person with Medicare or his/her personal representative must sign their name, fill in the date, and provide the phone number and address of the beneficiary. If you are a personal representative of the person with Medicare, check the box and also provide your address and phone number, as well as your relationship to the beneficiary. Attach a copy of the paperwork that shows you can act for that person (for example, Power of Attorney).

Section 6 If you are signing on behalf of the person with Medicare, check the box in section 6 and also provide your signature, address and phone number Attach a copy of the paperwork that shows you can act for that person (for example, power of attorney or executorship). **Please review your state laws for the requirements of a valid power of attorney.** recipient who is now deceased, please complete all sections of the form and include a copy of the legal documentation that indicates your authority to make a request for information. (For example: Executor/Executrix papers, next of kin attested by court documents with a court stamp and a judge's signature, a Letter of Testamentary or Administration with a court stamp and judge's signature, or personal representative papers and judge's signature.) **Please review your state laws for the requirements of a valid executorship.**	6. Send your completed, signed authorization to Medicare at the address shown here on your authorization form.
Revoke authorization In the future, if you, the person with Medicare, change your mind and do not want Medicare to give out your personal health information, write to the address shown on the authorization form and tell Medicare. Your letter will revoke your authorization and Medicare will no longer give out your personal health information (except for the personal health information Medicare has already given out based on your permission).	7. If, in the future, you change your mind and don't want Medicare to give out your personal health information, write to the address shown under number six on the authorization form and tell Medicare. Your letter will revoke your authorization and Medicare will no longer give out your personal health information (except for the personal health information Medicare has already given out based on your permission).

Authorization form crosswalk

Burden: The expectation is the burden will not increase or decrease due to the number of new beneficiaries entering the program which will balance out the number of forms submitted and processed in the first submission.

NEW FORM	OLD FORM
1. Used boxes to separate the sections to make it easier to understand where one section starts and the next one begins. 2. Added title of form, OMB number and form number 3. Moved "You should make a copy of your signed authorization for your records before mailing it to Medicare." to the end of the form. 4. Changed beneficiary to "person with Medicare" throughout document.	
Section 1 Use this form to ask Medicare to give out (disclose) your personal health information to the individual or organization you choose.	Use this form to ask Medicare to give out (disclose) your personal health information.
Section 2 **Medicare will only disclose the personal health information you want disclosed** **Check (✓) box 2A *or* 2B. *Do not check both boxes*.** **New York residents must also complete Box 2C.** ☐ 2A - **I want Medicare to release any information.**	Medicare will only disclose the personal health information you want disclosed. 2A: **Check only one box below to tell Medicare the specific personal health information you want disclosed:** ☐ Any Information (go to question 2b) ☐ Limited Information (go to question 2b) 2B: **Complete only if you selected "limited information". Check all that apply:**

OR

For limited disclosure of information, check the box 2B below and select the appropriate information to tell Medicare the specific personal health information you want disclosed:

☐ Information about your Medicare eligibility
☐ Information about your Medicare claims
☐ Information about plan enrollment (e.g. drug or MA Plan)
☐ Information about premium payments

☐ Other Specific Information (please write below; for example, payment information)

_____

2B – **I want Medicare to ONLY release the limited information ch** _____

Check all that apply.

- o Information about your Medicare eligibility
- o Information about your Medicare claims
- o Information about plan enrollment (e.g. drug or MA plan)
- o Information about premium payments

o Other specific information printed on the line below. ***If this circle is checked, you must include a description of information to be released or the request cannot be processed.)***

Other specific information printed on the line below. ***If this box is checked, you must include a description of information to be released or the request cannot be processed.)***

_____

_____ N/A

Section 3

How long should Medicare release the information to the authorized individuals or organization? *(This is subject to applicable law – for example, your state may limit how long Medicare may give out your personal health information.)*

Check only one box.

a)

☐ Disclose my personal health information indefinitely.

OR

b)

☐ Disclose my personal health information for a specified period:

_____ _____

Beginning date (mm/dd/yyyy) Ending date (mm/dd/yyyy)

(***If selecting b, you must include a stop and start date or the request cannot be processed.)***

Check only one box below indicating how long Medicare can use this authorization to disclose your personal health information (subject to applicable law—for example, your State may limit how long Medicare may give out your personal health information):

☐ Disclose my personal health information indefinitely.

☐ Disclose my personal health information for a specified period only beginning: (mm/dd/yyyy) _____ and ending: (mm/dd/yyyy) _____

Section 4

Fill in the name and address of the person(s) or organization(s) to whom you want Medicare to disclose your personal health information in the section(s) below.

Added "Required" to address line.

Fill in the name and address of the person(s) or organization(s) to whom you want Medicare to disclose your personal health information. Please provide the specific name of the person(s) for any organization you list below:

✓ ***If you need to list additional names, you may attach a sheet of paper to this form. (Include your name and Medicare number on the additional sheet.)***

✓ ***Please provide the specific name of the person(s) for any organization you listed below:***

Section 5

I authorize Medicare to disclose my personal health information listed in section 2 to the person(s) and/or organization(s) I have named on this form. I understand that my personal health information may be re-disclosed by the person(s) and/or organization(s) and may no longer be protected by law.

Added" If the person with Medicare signs section 5 above, do not complete section 6."

Moved representative information to section 6

Telephone Number ( )

I authorize Medicare to disclose my personal health information listed above to the person(s) or organization(s) I have named on this form. I understand that my personal health information may be re-disclosed by the person(s) or organization(s) and may no longer be protected by law.

Shows "Telephone Number"

NEW Section 6

Section 6 - For Personal Representative Only

Important information: This section should only be completed if someone other than the person with Medicare signs in section 5.

Check here if you are signing as a personal representative of the person with Medicare and complete the information below. Please attach the appropriate legal documentation (for example, Power of Attorney or Executorship). ***See the instructions on submitting the appropriate legal documents.***

Signature: _____

Print the personal representative's address (street address, city, state and ZIP Code):

_____

_____

Send the completed, signed authorization to:

Medicare BCC, Written Authorization Dept. PO Box 1270 Lawrence, KS 66044

_____	
Personal representative’s telephone number:	
Telephone Number ( )	Shows "Telephone Number"
Section 7	
Removed number 7 This section is not address in the instructions page	
Section 8	
Removed number 8 This section is not address in the instructions page	