BPAS

Information Release Authorization

When completed, mail or fax this form to BPAS at:
820 Gessner | Suite 1250 | Houston, TX 77024
Fax: (866) 254-2942 | bpas. com

Questions? Call us toll free at 1-866-401-5272

This form allows BPAS to release information related to your reimbursement account to the specific person(s) designated on this form (such as a spouse, family member, someone else closely involved in your medical care or an unrelated third party). Completion of this form will allow BPAS to communicate with such individual(s) who may contact us on your behalf. Related information includes account balance, payment amounts, date paid, and information specific to receipts received. The designated person(s) will be required to provide specific identifying information and should indicate there is a signed authorization form on file.

1. PARTICIPANT INFORMATION

LAST NAME | FIRST NAME | MI | Participant Social Security No. (SSN) or Secondary ID # (**REQUIRED**)

MAILING ADDRESS | ☐ Check here if new address | CITY | STATE | ZIP

DATE OF BIRTH | E-MAIL ADDRESS (home or personal recommended) ☐ Check here if new email address | AREA CODE and PHONE #

EMPLOYER NAME

2. DESIGNEE INFORMATION

FIRST DESIGNEE: LAST NAME | FIRST NAME | MI

MAILING ADDRESS | CITY | STATE | ZIP

DATE OF BIRTH | Relationship | AREA CODE and PHONE #

SECOND DESIGNEE: LAST NAME | FIRST NAME | MI

MAILING ADDRESS | CITY | STATE | ZIP

DATE OF BIRTH | RELATIONSHIP | AREA CODE and PHONE NUMBER

3. SIGNATURE

I understand that this voluntary authorization will stay on file and will not expire until I send a written request to revoke this authorization to the address or fax number above. I understand that I may revoke this authorization at any time by notifying BPAS in writing. BPAS may take action in reliance on this authorization prior to receipt of my written revocation of this authorization. Therefore, I understand that changes will not be considered applicable before BPAS receives the revocation.

Participant Signature | Date