Anthem

REQUEST TO CANCEL A RESTRICTION

Date of Request: _____
(Month/Day/Year)

Member's Name: _____
First Middle Last

Member ID Number: _____

Member's Date of Birth: _____
(Month/Day/Year)

Member's Address: _____
Street Address

_____

City State ZIP code

Requestor's Name (If different than member):_____
First Middle Last

Requestor's Relationship to the Member: _____

(Note: Written permission must be on file with Anthem so the information being requested can be released. If this permission is not on file, request a form to designate a Personal Representative and submit it to Anthem. This is not necessary for the parent of a minor child.)

Requestor's Phone Number: _____

Please cancel the restriction I requested on _____ (date required).
(Month/Day/Year)

I would like the restriction to be cancelled:

☐ Immediately (within five business days of receipt of this request by Anthem)

☐ As of the following date: _____
(Month/Day/Year)

Name and signature of requestor or member:

_____ _____ _____
Print Name Signature Date

Enclosures: Get help in another language
Nondiscrimination notice

anthem.com/inmedicaid **Serving Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect**