Appointment of Authorized Representative

Member Information (Printed)

Member Full Name: _____

Member Date of Birth: _____

Member Home/Street Address: _____

_____

Member Phone Number: _____

Member Identification Number: _____Group Number: _____

Representative Information

The following person(s), or company have the right to receive my protected health/personal information.

☐ Only for this reason/event: _____

_____

Representative Name: _____

Relationship to Member: _____

Information that may be released by Health Plan

I allow the following information to be disclosed on my behalf:

☐ Eligibility/Benefits

☐ Enrollment

☐ Claim Information

☐ Medical Information (diagnosis, medication)

☐ Premium/Billing Information

☐ Referral/Authorization of Services

Authorization Expiration Date: _____

I have read the contents of this authorization. I understand and allow the disclosure of my information as I have stated above.

Member Approval (Signature and Date)

Member Signature: _____

Date: _____