

Designation of Personal Representative

You may designate a personal representative who will act on your behalf in making decisions related to health care, which includes eligibility, benefits and/or payment issues. This individual can be a family member, friend, lawyer or unrelated party.

Please print neatly to ensure correct and prompt processing. We reserve the right to return any illegible or incomplete form.

1.) I hereby Authorize: _____
(Prescription Drug Plan/Company)

2.) To release information from the records of:
(Complete a separate form for each member)

Name: _____ Date of Birth: _____

Membership Number: _____

Address: _____

Home Phone: _____ Work Phone: _____

3.) I hereby designate the following individual(s) as my personal representative:

A. Name of individual: _____

Address: _____

City, State, Zip: _____ Telephone: _____

B. Name of individual: _____

Address: _____

City, State, Zip: _____ Telephone: _____

C. Name of individual: _____

Address: _____

City, State, Zip: _____ Telephone: _____

Please read each of the following statements carefully before signing this document.

1.) I understand that this designation will expire when my policy ends unless I indicate an expiration date or I revoke it.

Date to expire: _____

2.) I understand that this designation is voluntary and being made at my request.

3.) I understand that the released information may no longer be protected by federal privacy laws and may be re-disclosed by the individual or organization that receives the information.

4.) I understand that I may revoke this designation of personal representative at any time by sending a written notification to Medi-CareFirst at the address listed below, and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective for information that my Prescription Drug Plan has already used or disclosed, relying on this designation.

SECTION I: APPOINTMENT OF REPRESENTATIVE

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier)

I appoint this individual: _____ to act as my representative in connection with my claim or asserted right under title XVIII of the Social Security act (the “act”) and related provisions of title XI of the act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

Signature of Party Seeking Representation: _____ **Date:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number (with Area Code): _____

SECTION II: ACCEPTANCE OF APPOINTMENT

To be completed by the representative:

I am a/an _____ (Professional Status or relationship to the Party, e.g. attorney, relative, etc.)

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

Signature of Representative: _____ **Date:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number (with Area Code): _____

If you need help completing this form, please call Medi-CareFirst toll-free at Membership Customer Service at 1 (888) 857-6118, (October 15 to February 14): 8 a.m. to 8 p.m., 7 days a week; (February 15 to October 14): 8 a.m. to 8 p.m., Monday through Saturday. TTY users should call 1 (800) 855-2880.

Please mail or fax this authorization to:

Medi-CareFirst BlueCross BlueShield
Membership Customer Service
c/o CGI, Inc.
P.O. Box 2668
Fort Worth, TX 76113
Fax: 1-888-524-6787

Please keep a copy of the designation. We will provide you with a signed copy of this designation upon request.

If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits the recipient of the information from making any further disclosure of this information unless such disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Medi-CareFirst BlueCross BlueShield is the business name of Group Hospitalization and Medical Services, Inc. and First Care, Inc., and each is an independent licensee of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association. ®' Registered trademark of CareFirst of Maryland, Inc.