



Personal Representative Information (required for privacy verification purposes)

Name (Last, First, MI): _____ Gender: M F Undisclosed

Last 4 Digits of Social Security #: _____ Date of Birth: _____ / _____ / _____
MM DD YYYY

Address: _____

City: _____ State: _____ ZIP: _____

Telephone #: _____ - _____ - _____ Relationship to the member: _____

Time Period for Representation: From: _____ / _____ / _____ To: _____ / _____ / _____
MM DD YYYY MM DD YYYY

NOTE: If no time period is provided, this request will remain in effect until the member or his/her limited personal representative notifies HORIZON in writing requesting a change.

Check here if you want your response to this request sent via email.

Email address: _____

I have read the contents of this form. I understand, agree, and allow Horizon BCBSNJ to discuss and/or disclose my information as I have stated above. I understand that Horizon BCBSNJ does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or eligibility benefits. I understand I am entitled to a copy of this form and agree that a photocopy is as valid as the original. I understand that I may revoke this authorization at any time by notifying Horizon BCBSNJ in writing at the address provided below. I understand that a revocation will not apply to information that was already disclosed. I understand that once information has been disclosed according to these instructions, the Health Insurance Portability and Accountability Act (HIPAA) and other privacy laws may no longer protect the information.

Signature of **Member** **Requestor:** _____ **Date:** _____ / _____ / _____
(check whether member or other requestor) MM DD YYYY

Printed Name: _____

INSTRUCTIONS

REQUEST FOR APPOINTMENT OF LIMITED PERSONAL REPRESENTATIVE

(NOTE: This form cannot be used for a member's change of address.
For member change of address, please contact Customer Service)

General Instructions: All fields are required to be completed unless otherwise specified.

Use this form if you wish to allow your personal health information to be disclosed to another person. This person will not be permitted to make changes to your policy or other information. This form cannot be used to assign a person as your legal personal representative with the right to act on your behalf. If you wish to assign a legal personal representative please complete the Documentation of Legal Personal Representative Status for Member form.

Member's Information Section:

This section requests information related to the member for which a limited personal representative is being requested. Since this information is used for both identification and verification purposes, the information included in this section should match the most current information for the member/subscriber that Horizon BCBSNJ's has on file. Please, be aware that this form may be denied if the information on the form does not match the information in our records.

Limited Personal Representative Information Section:

The requested information in this section will be used by Horizon BCBSNJ for identification and verification purposes. The limited personal representative will be required to verify this information during a phone call if they wish to receive your personal health information. Time Period of Representation: If no termination date is entered, the request will remain in effect until the Member or legal personal representative notifies the change to Horizon BCBSNJ in writing.

Note: The appointment will be effective on the date that Horizon BCBSNJ processes and approves the form.

Mail this form to:

Horizon BCBSNJ, Attn: HIPAA Appeals Unit
PO Box 1458
Newark, NJ 07101-1458

Or Fax to: (973) 274-2358

This form is also available for online submission via Horizon BCBSNJ Member Portal at HorizonBlue.com