

## **Request for Appointment of Limited Personal Representative for Member**

Use this form if you wish to allow your personal health information to be disclosed to the person named below so they can assist you with your health care and payment for health care. This person will not be permitted to make policy changes.

Read instructions on PAGE 3 before completing this form. ALL FIELDS MUST BE COMPLETED.

A separate form is required for <u>each member</u> on the policy. Please print legibly, except where signature is required.

This form applies to all Horizon BCBSNJ-issued products.

Please complete the information below, sign in the space provided and return to: Horizon Blue Cross Blue Shield of New Jersey, Attn: HIPAA Team, P.O. Box 1458, Newark, New Jersey 07101-1458 or via fax at 973-274-2358. This form is also available for online submission via Horizon BCBSNJ Member Portal at HorizonBlue.com

Member's Information			
Name ( Subscriber Dependent):			
Subscriber Identification #:			
Date of Birth: / / MM DD YYYY	Telephone #:		
Address (on file):			
City:		State:	ZIP:
l,(member)	, hereby designate		onal representative)
(member)		minicu perse	

as my limited personal representative. I understand this request applies to communications from Horizon BCBSNJ and its business associates about my private information.

### Information that Horizon BCBSNJ may disclose:

I authorize Horizon BCBSNJ to disclose the following information to my limited personal representative:

□ Option 1: All my information, including potentially sensitive information. This may include a *diagnosis* (name of illness or condition), *procedure* (type of treatment), *claims, the name of my doctors* and *other health care providers*, and *financial information* (like billing and banking). Horizon is permitted to disclose information related to mental or behavioral health, substance use disorders (including alcohol abuse).

Please note for certain behavioral health disclosures you may be required to provide additional authorizations.

□ Option 2: **All my information, BUT NOT sensitive information**. For non-sensitive information, this may include a diagnosis (name of illness or condition), *procedure* (type of treatment), *claims, the name of my doctors* and *other health care providers*, and *financial information* (like billing and banking). However, Horizon <u>is NOT</u> <u>permitted to disclose</u> this information related to mental or behavioral health, substance use disorders (including alcohol abuse). Please be advised that Horizon will disclose the name of your doctors and other health care providers, which may be an indication of a sesitive service, to your Limited Personal Representative.



<b>Personal Representative</b>	Information	(required	for privacy	verification	purposes
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Name (Last, First, MI):	Gender:	: □M	□F□U	Indisclo	osed
Last 4 Digits of Social Security #: Da	te of Birth:	MM	/ DD	/	YY
Address:					
City:	_State:	;	ZIP:		
Telephone #:	r:				
Time Period for Representation: From: / / To: / To: / DD	_/				
<b>NOTE:</b> If no time period is provided, this request will remain in effect until the representative notifies Horizon in writing requesting a change.	member or h	nis/hei	r limited	l persoi	nal

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 <u>cannot be used</u> 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 <u>cannot</u> 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 <u>Documentation of Legal Personal Representative Status for Member</u> 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