RESET

# 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 each member on the policy. Please print legibly, except where signature is required.

This form applies to all Braven Health-issued products.

Please complete the information below, sign in the space provided and return to: Braven Health, 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 Braven Health Member Portal at BravenHealth.com

## Member's Information

Name (☐ *Subscriber* ☐ *Dependent*): _____

Subscriber Identification #: | | | | | | | | | | | | | | | |

Date of Birth: ____/____/____ (MM DD YYYY) Telephone #: ____-____-____

Address (on file): _____

City: _____ State: _____ ZIP: _____

I, _____ (*member*), hereby designate _____ (*limited personal representative*)

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

## Information that Braven Health may disclose:

I authorize Braven Health 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). Braven Health is permitted to disclose information related to HIV or AIDS, sexually transmitted disease, mental or behavioral health, substance use disorders (including alcohol abuse), genetic information, and sexual health (family planning & contraception, abortion, and pregnancy).

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

☐ Option 2: **All my information, BUT NOT sensitive information.** Braven Health is NOT permitted to disclose sensitive information, which may include a diagnosis (name of illness or condition), procedure (type of treatment), or claims payment message that relates to HIV or AIDS, sexually transmitted disease, mental or behavioral health, substance use disorders (including alcohol abuse), genetic information, and sexual health (family planning & contraception, abortion, and pregnancy). Please be advised that Braven Health will disclose the name of your doctors and other health care providers, which may be an indication of a sensitive service, to your Limited Personal Representative.

Braven HEALTH

## 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 Braven Health 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 Braven Health to discuss and/or disclose my information as I have stated above. I understand that Braven Health 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 Braven Health 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 Braven Health'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 Braven Health 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 Braven Health in writing.

**Note:** The appointment will be effective on the date that Braven Health processes and approves the form.

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**Mail this form to:**

Braven Health
Attn: HIPAA Appeals Unit
PO Box 1458
Newark, NJ 07105-1458

**Or Fax to:** (973) 274-2358

This form is also available for online submission via Braven Health Member Portal at BravenHealth.com