[Please Print]

Personal Representative Request Form

This form identifies a person who has legal authority to act on a member's behalf in making decisions related to the member's health care. This provision applies to persons with legal guardianship, power of attorney, or other documented legal authority to act on behalf of a member. **Questions regarding this form should be directed to the Member Services Department at the number located on the back of the member's identification (ID) card**.

Member Information: (Include any letters in front of the identification number on the member ID card.)

Name: (First, Middle, Last, Title)		**Member ID Number:**
Address: (including zip code)		**Date of Birth:** (Month/Day/Year)
Home Telephone Number: (including area code)	**Daytime Telephone Number:** (including area code)	**Gender:** ☐ Male ☐ Female

Health Plan: (The Health Plan is your insurance carrier or HMO. Please enter the Health Plan name as it appears on the member's ID card.)

Personal Representative Information:

Name: (First, Middle, Last, Title)	**Personal Rep. Mother's Maiden Name:** (will be used for identity verification)
Address: (including zip code)	**Telephone Number:** (including area code)

A copy of a Power of Attorney or other legal document must be attached to this form in order for it to be processed. Attach supporting documentation and describe (for example: Power of Attorney for health care decisions, Custodial Order, Executor of Estate).

Type of Documentation:

Signature/Date: (The member's legal Personal Representative must sign and date this form for it to be processed.)

Print Name: ____

Personal Representative Signature: ______________________________

Date: ____

Important Information about Personal Representatives

- The federal Privacy Rule requires your Health Plan to follow certain procedures before it may provide access to your Protected Health Information (PHI) to someone other than you. PHI is information about you that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, and the provision of health care to you or the payments for that care.

- Your Health Plan will release PHI to your Personal Representative upon receipt of documentation supporting their legal authority to make health-related decisions on your behalf (for example: a valid Power of Attorney, guardianship or other legal document).

- Your Health Plan will also recognize as a Personal Representative an executor, administrator, or a person recognized by law as having authority to act on behalf of a deceased member or the member's estate.

- Your Health Plan will not however, treat someone as your Personal Representative if we reasonably believe: (1) you may be subject to domestic violence, abuse or neglect by the Personal Representative; (2) treating the person as your Personal Representative could endanger you; or (3) in the exercise of professional judgment (for example, in a licensed professional's judgement), your Health Plan decides that it is not in your best interest to treat the person as your Personal Representative.

- A Personal Representative designation will remain in effect until the member, a court order, or an applicable law revokes it.

- To assist your Health Plan in responding to this request, please complete this form by printing or typing into the spaces provided. Attach additional pages if necessary to clarify your request. Attach a copy of the document supporting your Personal Representative's legal authority to act on your behalf.

- Mail or fax the completed form and supporting documentation to:

Member Correspondence
P.O. Box 41890
Philadelphia, PA 19101-1890
Fax Number: 215-241-2042 or 1-888-457-3013 (Toll Free)

- If you have any questions about his form, please call the Member Services Department at the number on the back of your member identification card.