# 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.)

<table>
<thead>
<tr>
<th>Name: (First, Middle, Last, Title)</th>
<th>Member ID Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address: (including zip code)</td>
<td>Date of Birth: (Month/Day/Year)</td>
</tr>
<tr>
<td>Home Telephone Number: (including area code)</td>
<td>Daytime Telephone Number: (including area code)</td>
</tr>
<tr>
<td>Gender: ☐ Male ☐ Female</td>
<td></td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Name: (First, Middle, Last, Title)</th>
<th>Personal Rep. Mother’s Maiden Name: (will be used for identity verification)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address: (including zip code)</td>
<td>Telephone Number: (including area code)</td>
</tr>
</tbody>
</table>

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 this form, please call the Member Services Department at the number on the back of your member identification card.
Language Assistance Services


Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。


Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: सूचना: हे तम्हें गुजराती बोलता हो, तो नि:शुल्क लाभ सहायता सेवाएं तपासा करा उपलब्ध करे. 1-800-275-2583 कॉल करे.


Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic: الملاحظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متوفرة لك بالمجان. اتصل برقم 2583-800-1.


Hindi: व्याख्या है: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाओं उपलब्ध हैं। कॉल करें 1-800-275-2583।


Japanese: 備考：母国語が日本語の方は、言語アシスタントサービス（無料）をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi): نویج: اگر فارسی صحبت می‌کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می‌شود. با شماره 800-275-2583 تماس بگیرید.


Urdu: توجيه: اگر آپ اردی زبان بولتے ہیں تو آپ کے لیے مفت میں زبان معاونہ خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583

Mon-Khmer, Cambodian: សំដៅ: ប្រឈមព្រឹត្តិការណ៍ នីមួយៗនៃជំនាញសំរាប់ក្នុងប្រទេសជាតិដែល ស្គាល់ប្រៀបធៀបជាមួយក្នុងប្រទេសប្រចាំពេលកំពុងរក្សាទុក គេហទាន់ល្បីប្រទេស 1-800-275-2583។

Y0041_HM_17_47643 Accepted 10/14/2016

Taglines as of 10/14/2016
Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.