Personal Representative Request

The purpose of implementing a Personal Representative is to enable another individual to act on your behalf with respect to:

- making decisions about your health benefits,
- requesting and/or disclosing your protected health information, and
- exercising all of the rights you have under your health benefit plan.

A Personal Representative may either be legally appointed, or designated by a Customer to act on his or her behalf:

- When a Personal Representative has been legally appointed, the Personal Representative should complete and sign this form. Supporting legal documentation, such as a power-of-attorney that indicates full health care decision-making authority or guardianship papers, must be submitted with this form.
- When a Personal Representative is being designated by a Customer, the Customer needs to sign this form in the presence of a Notary Public.

Important: Except for Cigna Home Delivery Pharmacy materials, all Customer mailings will be directed to the Personal Representative's address.

Cigna Home Delivery Pharmacy will continue to send the medications, accompanying information and other communications directly to the Customer (not to the Personal Representative) at the address Cigna Home Delivery Pharmacy has on file for the Customer, If medications and communications are to be sent tto the Personal Representative, please call Cigna Home Delivery Pharmacy at 1.800.Tel-Drug.

The Customer retains his or her right to act on his or her own behalf unless CareAllies receives legal documentation dictating otherwise.

Note: If your request is granted, it will affect only written and oral communications from CareAllies. If you also wish your employer, group health plan, physician or anyone outside of CareAllies to make this change, you must obtain their agreement separately.

Verification – (Please Print)

Identification of Customer:

(The following information is needed for verification.)

Name of Customer: _____ Date of Birth: _____

Phone Number where we can reach you if we need to contact you to process your request (required): _____

Social Security # (Optional): _____

Customer ID card number (if applicable): _____

Group or Account # on ID card: _____

Subscriber Name (if different from Customer): _____

Subscriber's Relationship to Customer: _____

Subscriber's Employer Name: _____

Subscriber's Social Security Number (if different from Customer) (Optional): _____

Please Complete Next Page ↪

CareAllies®

If you have additional coverage with CareAllies, other than that which is described above, please provide the following information as well:

Other Employer Name: _____

Number on Customer ID card: _____

Group or Account Number on ID card: _____

Does this request apply to all coverage? ☐ Yes ☐ No

Identification of Personal Representative:

Name of Personal Representative: (only one person can be named) _____

Relationship to Customer: _____

Date of Birth of Personal Representative: (answer in the following 8-digit format: 11231949 for November 23, 1949) _____

Address where communications about this Customer should be sent:

_____

What is the reason for this request? _____

Verification questions for personal representative

(In this section "You" and Your" refer to the Personal Representative.)

The answers you provide below will be used to verify your identity if you call for protected health information about the Customer. Note that we ask these questions because the answers should be easy for you to remember, but you may enter other numbers as described below.

4 digit PIN (you may use any four digit number) _____

What is your mother's date of birth? (answer in the following 8-digit format: 11231949 for November 23, 1949) _____
You may use any date, however, it cannot be a future date, and it must be a legitimate calendar date. For example, we cannot accept 11361949 (November 36, 1949) because there are not 36 days in November. We also cannot accept 11232015 (November 23, 2015) because 2015 is a future date.

- Please DO NOT provide anyone else with the answers to these questions.
- You should keep a copy of this form for reference.

Please note

- If the information on this form is not complete, CareAllies will return the form to you, and this request will not be considered until CareAllies receives complete information.
- If your Customer ID or date of birth is changed, another form will need to be completed at that time.
- If either the Customer or Group changes to a different type of health care benefits coverage provided by CareAllies, another form will need to be completed at that time.
- Any previous request to send information to an alternate address will be disregarded. All future Customer correspondence will be sent to the address specified above.
- You may change or revoke this request by sending a written request to CareAllies, Central HIPAA Unit, at the address on the following page.

Please Complete Next Page ↪

Signature

Personal Representatives who are appointed by a court order or other legal documentation, ***please complete section A.***
Personal Representatives who are designated by a Customer, ***please proceed to sections B and C.***

A. Personal Representatives who are legally appointed:

I have read and understand the above information. I acknowledge that by signing this form I have the legal authority to act on behalf of the Customer.

Signature of Personal Representative _____ **Date:** _____

To safeguard privacy and help make sure no one other than the person whom the Customer designates receives Protected Health Information, this request must be submitted with appropriate supporting legal documentation.

B. Personal Representatives designated by a Customer

To safeguard privacy and help make sure no one other than the person whom the Customer designates receives Protected Health Information, this request must be signed by the Customer and be notarized. (Notary services often can be provided free at a bank where you have an account).

I have read and understand the above information. I acknowledge that by signing this form I authorize CareAllies to treat my Personal Representative as myself.

Signature of Customer/Parent/Guardian *(This line is for the Customer to sign, authorizing the Personal Representative.)*

_____ **Date:** _____

If request is made by a Parent/Guardian for a minor child, complete the following:

Customer is a minor ____ years of age. If you are making this request on behalf of a minor child, we may require additional information before this request is considered complete.

Please Return This Completed Form To:
CareAllies • PRIVACY OFFICE HIPAA UNIT • PO Box 188014 • Chattanooga TN 37422
Fax: 877.815.4827 or 859.410.2419