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HEALTH PARTNERS

PERSONAL REPRESENTATIVE DESIGNATION REQUEST

Please be sure to read this form carefully, including the information about your rights offered below.

Member Information

Member Name _____

Member ID Number _____

Date of Birth _____

Address _____

Phone Numbers: Cell/Mobile _____ Home _____

(E-mail) _____

Subscriber Information (if different from above)

Name _____

Address _____

Personal Representative Information

Name _____

Address _____

Phone Numbers: Cell/Mobile _____ Home _____

Required Signatures

Member (or Tutor) _____ Date _____

Personal Representative _____ Date _____

If the Member is a minor or otherwise legally incompetent, please provide the name, address, and relationship to the Member, of the person signing this request.

Name _____ Relationship _____

Address _____

Are there any limitations on the information your Personal Representative may have access to? **Yes _____ No _____**
If yes, please specify (examples: claims payments, pharmacy history, certain healthcare services received, etc.)

Is this a temporary authorization/designation? **Yes _____ No _____**
If yes, please specify the expiration date: _____

For your convenience, you may mail or fax this request as follows:

Mail:
AllWays Health Partners
Customer Service Department
399 Revolution Drive – Suite 820
Somerville, MA 02145

Fax:
AllWays Health Partners
Customer Service Department
617-526-1985

Important Information

- You have the right to choose one or more persons to act on your behalf with respect to the protected health information that pertains to you.
- If you would like to exercise this right, please complete and return this form.
- By submitting this form, you are informing AllWays Health Partners that you wish to designate the individual(s) named within this form as your authorized Personal Representative(s).
- This form is not a Health Care Proxy and does not authorize your Personal Representative(s) to make medical decisions on your behalf; it only gives your Personal Representative(s) permission to access and inquire about your Protected Health Information (PHI) on file with AllWays Health Plan, subject to any limitations you may have indicated.
- Upon receipt of this completed, signed, and dated form, AllWays Health Partners can verify your request, adjust our records accordingly, and speak to your Personal Representative in the future.
- Please note that you may revoke this designation at any time by submitting a written request to terminate such.