



BMC HealthNet Plan Personal Representative Designation Request Form

bmchp.org | MA Health: 888-566-0010
 QHP including ConnectorCare: 855-833-8120
 TTY: 711

Please Note: This form is used to designate someone to whom you give authority to act on your behalf. By designating a Personal Representative, you are authorizing Boston Medical Center HealthNet Plan to provide your Personal Representative with access to your member information. All fields are required. Incomplete or incorrect forms will be returned.

Member Information (Please print information clearly)			
YOUR MEMBER ID NUMBER (FOUND ON YOUR BMC HEALTHNET PLAN ID CARD)		DATE OF BIRTH	
MEMBER'S LAST NAME			
FIRST NAME		MIDDLE INITIAL	
ADDRESS	CITY	STATE	ZIP CODE
PHONE			

Personal Representative Information	
I designate the following individual to act as my Personal Representative.	
PERSONAL REPRESENTATIVE NAME (PLEASE PRINT)	DATE OF BIRTH
RELATIONSHIP TO MEMBER	

Special Categories (please initial all that apply)			
State law requires that you give specific permission to release the information below. Indicate your permission for BMC HealthNet Plan to provide your Personal Representative with access to any of the following information by <u>initialing all that apply</u> .			
GENETIC TESTING AND RESULTS		SEXUAL ASSAULT	
MENTAL / BEHAVIORAL HEALTH		SUBSTANCE / ALCOHOL ABUSE	
DOMESTIC VIOLENCE		SEXUALLY TRANSMITTED DISEASES (STD)	
HIV/AIDS		MAMMOGRAPHY REPORTS	
ABORTION			

As my personal representative, I authorize the individual named above to act on my behalf in regard to my health care coverage provided to me through Boston Medical Center HealthNet Plan. BMC HealthNet Plan may disclose my health information (e.g., health, claims, or payment information) to my Personal Representative and respond to questions from my Personal Representative on my behalf in the same manner and to the same extent that BMC HealthNet Plan would disclose information to me. BMC HealthNet Plan will continue to send written correspondences regarding my benefits and coverage to me and in accordance with BMC HealthNet Plan's policies, unless I specify otherwise.

I understand that this designation is valid until I revoke or amend it by sending a completed "Notice of Revocation of Designation of Personal Representative" form or other similar written notice to BMC HealthNet Plan at the address below. I understand that any revocation of my designation of a Personal Representative will be effective upon receipt and processing of my written revocation and that the revocation will not be valid where BMC HealthNet Plan has already acted in reliance upon my designation.

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided by law. I understand that, upon request, I must be provided a list of entities to which my alcohol and/or drug treatment information has been disclosed.

Signature of Member

Date

If the member is under age 18, the parent or guardian must sign below.

Signature of Parent or Guardian

Date

Printed Name of Parent or Guardian

Date

****BMC HEALTHNET PLAN USE ONLY****

REQUEST RECEIVED BY:

DATE (MM/DD/YYYY)

Mail or Fax Completed form to:

BMC HealthNet Plan
Attention: Member Services Dept.
529 Main Street, Suite 500
Charlestown, MA 02129

Fax: 617-897-0884

Phone:

MA Health: 888-566-0010

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