Assign a Personal Representative Form

How to Use This Form: This form is used to give or remove someone's authority to act on your behalf. By designating a Personal Representative, you are authorizing WellSense to provide your Personal Representative with access to your member information. All fields are required. Incomplete or incorrect forms will be returned.

NOTE: If you need someone to act on your behalf to help you file an appeal, grievance, or coverage request, you must also complete an **Appointment of Representative form** (for Medicare) or an **Assign an Appeals Representative form** (for all other products) which can be found in the member section of our website under Documents and Forms.

Member Information (please print information clearly)		
Your Member ID Number (found on your plan ID card)		
Member's Last Name		
Member's First Name		Middle Initial
Address		
City	State	Zip Code
Phone		

Product Information	
Please select all products that apply to you:	
Massachusetts	**New Hampshire**
☐ MassHealth ☐ Clarity plans ☐ Senior Care Options	☐ NH Medicaid ☐ NH Medicare Advantage HMO

Type of Request

Type of Request	Instructions
☐ Initial (New)	This box is to initiate a new designation and is effective upon WellSense's receipt and processing until you submit a modification or revocation. Complete entire form.
☐ Modify (Change)	This box is to modify an existing designation and is effective upon WellSense's receipt and processing. Complete entire form.
☐ Revoke/End as of _____ (mm/dd/yyyy)	This box ends an existing designation and is effective upon the date you enter. WellSense is not responsible for acting in good faith prior to receipt and processing of this request. You only need to complete the Member Information, Product Information, Type of Request and Signature sections of this form.

Special Categories (please initial all that apply)

We may need your specific permission to share sensitive PHI with others including your Personal Representative. The special PHI listed below may not represent benefits you are eligible for under your plan. Some of the special PHI listed below may apply to you. **Please initial the box(es) if you give us permission to share it.**

	Initial		Initial
Genetic testing and results		Sexual assault	
Mental health/behavioral health		Substance/alcohol abuse	
Domestic violence		Sexually transmitted diseases (STD)	
HIV/AIDS		Mammography Reports	
Abortion			

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.

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	
Address	

City	State	Zip code
Phone		
Signature of Personal Representative		

I understand that, if the parties I authorize to receive and/or use my PHI are not subject to federal health information privacy laws, they may disclose my PHI and it may no longer be protected under federal health information privacy laws.

Please note: WellSense does not maintain treatment records. WellSense must keep your PHI private. By signing this form, you allow us to share your PHI as instructed. Your decision will not impact your enrollment in WellSense.

Member Signature	
By signing below, I knowingly, willingly, and voluntarily authorize WellSense to act as requested on this form. I have read and understand the terms of this form and may contact WellSense to ask questions about this form and its purpose.	
Signature	Date

Mail or fax completed form to:

WellSense Health Plan
Attn: Member Services Department
529 Main Street, Suite 500
Charlestown, MA 02129
Fax: 617-897-0884