Personal Representative Designation Request Form

How to Use This Form: 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 WellSense to provide your Personal Representative with access to your member information. All fields are required. Incomplete or incorrect forms will be returned. You may be required to complete an Appointment of Representative Form to appoint an individual to act on your behalf for a grievance, coverage request, or appeal.

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	
I understand that this form applies to all coverage as indicated below:	
Check here	**Type of Coverage**
	WellSense Medicaid
	WellSense Medicare Advantage HMO
	Both. Please select this box if you want this form to apply to both your Medicaid and Medicare Advantage coverage with WellSense.

Type of Request		
Check here	**Type of Request**	**Instructions**
	Initial (New)	This box is to initiate a new request and is effective upon the Plan's receipt and processing until you submit a modification or revocation. Complete entire form.
	Modify (Change)	This box is to modify an existing request and is effective upon the Plan's receipt and processing. Complete entire form.
	Revoke/End as of ________________ (mm/dd/yyyy)	This box ends an existing request and is effective upon the date you enter. The Plan 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.

All fields are required to be filled out. Incomplete or incorrect forms will be returned.

Special Categories (please initial all that apply)			
We may need your specific permission to share sensitive PHI with others. 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.**			
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	

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

Member Signature	
By signing below, I knowingly, willingly, and voluntarily authorize the Plan to act as requested on this form. I have read and understand the terms of this form and may contact the Plan 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

WellSense Medicare Advantage Member Services: 855-833-8128 (TTY: 711)
WellSense NH Medicaid Member Services: 877-957-1300 (TTY: 711)