WELL SENSE HEALTH PLAN

wellsense.org | 877-957-1300

Well Sense Health Plan Personal Representative Designation Request Form

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 WELL SENSE HEALTH 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) / PHONE NUMBER	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 Well Sense HealthPlan to provide your Personal Representative with access to any of the following information by **initialing all that apply**.

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 Well Sense Health Plan. Well Sense Health 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 Well Sense Health Plan would disclose information to me. Well Sense Health Plan will continue to send written correspondences regarding my benefits and coverage to me and in accordance with Well Sense Health 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 Well Sense Health 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 Well Sense Health 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
If the member is under age 18, the parent or guardian must sign below. Date

Signature of Parent or Guardian Date

Printed Name of Parent or Guardian Date

****WELL SENSE HEALTH PLAN USE ONLY****	
REQUEST RECEIVED BY:	DATE (MM/DD/YYYY)

Mail or Fax Completed form to:

Well Sense Health Plan
Attention: Member Services Dept.
529 Main Street, Suite 500
Charlestown, MA 02129

Fax: 617-897-0884
Phone: 877-957-1300