Personal Representative Request Form
Important Information about Personal Representatives

The HIPAA Privacy Rule requires MedCost and MedCost Benefit Services (MBS) to follow certain procedures before it may provide access to your Protected Health Information (PHI) to someone other than you. PHI is information about you that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, and the provision of health care to you or the payments for that care.

You have the right to authorize that the PHI held by MedCost and MBS be released to and/or received by persons or organizations you identify. The person or organization you identify on the Personal Representative Request Form may not be subject to the HIPAA Privacy Rule. If this is the case, your appointed Personal Representative may further release your confidential information without protection from federal or state privacy laws.

Appointing a Personal Representative is voluntary.

MedCost and MBS will not treat someone as your Personal Representative if (1) we reasonably believe you may be subject to domestic violence, abuse or neglect by the Personal Representative; (2) treating the person as your Personal Representative could endanger you; or (3) in the exercise of professional judgment (for example, in a licensed professional's judgment), we decide that it is not in your best interest to treat the person as your Personal Representative.

To assist MedCost and MBS in responding to your request to appoint a Personal Representative, please complete the following form by printing or typing into the spaces provided. Attach additional pages if necessary to clarify your request. Attach a copy of the document supporting your personal representative's legal authority to act on behalf in decisions related to health care. If you are giving permission to MedCost and MBS to share the PHI of your minor child (ren), please complete the applicable section of the form below.

Please email the completed form to: personalrepforms@medcost.com

or

Mail or fax the completed form and supporting documentation to:
Privacy Official
MedCost
PO Box 25347
Winston-Salem, NC 27114-5347
336-970-2279 (fax)

If you have any questions about this form, please telephone a MedCost and MBS Customer Service representative at (800) 795-1023.

Personal Representative Request Form

Please complete and sign this form to appoint a personal representative. MedCost will provide your appointed personal representative the same rights to your Protected Health Information (PHI) that are provided to you.
Questions regarding this form should be directed to MedCost and MBS Customer Service (800) 795-1023.

MEMBER APPOINTING A PERSONAL REPRESENTATIVE

Name (First, Middle, Last, Title):	Date of Birth (Month/Day/Year):	Gender:
Address (Street, City, State, Zip):	Home Telephone (include Area Code):	
Group Health Plan (as appears on ID card):	Member Number (as appears on ID card):	

WHO IS THE PERSONAL REPRESENTATIVE WHO WILL HAVE ACCESS TO YOUR PERSONAL HEALTH INFORMATION?

Name (First, Middle, Last, Title):	Home Telephone (include Area Code):
Address (Street, City, State, Zip):	Personal Representative's Relationship to Me:

IF YOU ARE GRANTING ACCESS TO PHI OF COVERED MINOR CHILD TO ANOTHER PERSON

Name of person to whom you are granting this access (First, Middle, Last, Title):	Home Telephone (include Area Code):	
Address (Street, City, State, Zip):	Personal Representative's Relationship to the Children:	
Child's Name (First, Middle, Last, Title):	Date of Birth (Month/Day/Year):	Gender:
Child's Name (First, Middle, Last, Title):	Date of Birth (Month/Day/Year):	Gender:
Child's Name (First, Middle, Last, Title):	Date of Birth (Month/Day/Year):	Gender:

AUTHORIZATION TO APPOINT A PERSONAL REPRESENTATIVE

1 Please state the purpose of this authorization
- ☐ (a) To appoint a personal representative to act on my and/or my minor children's behalf for decisions related to health care.
- ☐ (b) Verbal release of **(circle all that apply):** claims information, benefit confirmation/eligibility, EOB information
- ☐ (c) Other: For the following purpose (please specify and describe in detail):

2 I hereby authorize the request and release of PHI held by MedCost to the above personal representative. By appointing the person named on this form as a personal representative, I understand that I am authorizing the MedCost to give this person access to PHI, the right to talk to MedCost about medical care, and the right to make decisions that will bind me.

3 I represent that the person I am appointing has agreed to act as my and /or my minor children's personal representative.
I understand that my Personal Representative designation remains in effect until a court order, an applicable law, or I revoke it.

Member Signature: (required)	Personal Representative Signature: *Personal Representative Signature not required for options 1(b) or 1(c) above
Date Signed:	Date Signed: