

Personal Representative Form

Please print clearly in blue or black ink.



A product of AmeriHealth Caritas Louisiana, Inc.

In order for this Personal Representative Form to be processed by AmeriHealth Caritas Next:

- The form must be completely filled out.
- A copy of the legal document referred to on this page must be attached to this form.

The Personal Representative Form lists the person who has legal authority to act on your behalf to make health care decisions. This information will remain on file with AmeriHealth Caritas Next until revoked by you, or revoked by a court order or law.

If you have questions, please call Member Services at **1-833-282-2252 (TTY 711)**.

Member information

| | | |
|--|-----------------------------|-----------------|
| First name: | | Middle initial: |
| Last name: | Date of birth (MM/DD/YYYY): | |
| Member ID (See ID card.): | | |
| Address line 1: | | |
| Address line 2: | | |
| City: | State: | ZIP code: |
| Home phone number (including area code): | | |
| Mobile phone number (including area code): | | |
| Email address: | | |

Personal representative information

| | | |
|--|-----------------------------|-----------------|
| First name: | | Middle initial: |
| Last name: | | |
| Address line 1: | | |
| Address line 2: | | |
| City: | State: | ZIP code: |
| Home phone number (including area code): | | |
| Mobile phone number (including area code): | | |
| Email address: | | |
| Relationship to member: | Date of birth (MM/DD/YYYY): | |

**A copy of legal documentation must be attached to this form.
If you do not attach legal documentation, this form cannot be processed.**

| | |
|--|---|
| Type of document you are attaching: | |
| <input type="checkbox"/> Health care power of attorney <input type="checkbox"/> Guardianship court order (for health care decisions) <input type="checkbox"/> Custodial court order <input type="checkbox"/> Executor of estate (Member is deceased.) | <input type="checkbox"/> Other (Please explain.): |

Signature and date of member's legal personal representative

| | |
|--------------------------------------|--------------------|
| Name (print): | |
| Personal representative's signature: | Date (MM/DD/YYYY): |

Please keep a copy of this form for your records.



Important information about personal representatives

The federal Privacy Rule requires AmeriHealth Caritas Next to follow certain steps 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. AmeriHealth Caritas Next will release PHI to your personal representative after we receive a document that supports their legal authority to make health care decisions on your behalf (for example, a valid power of attorney, guardianship, or other legal document). AmeriHealth Caritas Next will also recognize as a personal representative an executor, an administrator, or a person recognized by law as having authority to act on behalf of a deceased member or the member's estate.

We care about your privacy

Information about your health is very personal. We are committed to protecting your privacy. Please read this form carefully. This form will need to be entirely filled out for it to be processed. This includes attaching legal documentation.

AmeriHealth Caritas Next will not treat someone as your personal representative if we reasonably believe (1) you may be subject to domestic violence, abuse, or neglect by the personal representative; (2) treating the person as your personal representative could put you in danger; or (3) in the exercise of professional judgment (for example, in a licensed professional's judgment), that it is not in your best interest to treat the person as your personal representative.

We care about your well-being

We care about your well-being. If we think your personal representative will misuse your health information, we will not give it to them.

A personal representative designation will remain in effect until the member, a court order, or a law revokes it.

Completing the form

If you name a personal representative, this form will remain in effect until it is canceled. You can cancel this authority at any time. You just have to tell us by calling Member Services at **1-833-282-2252 (TTY 711)**. A court order or other laws can also cancel it.

To help AmeriHealth Caritas Next respond to this request, please complete this form by printing or typing into the spaces provided. Attach more pages if needed to make your request clear. Attach a copy of the document that says your personal representative has legal authority to act on your behalf.

Where to mail the form

Mail the completed form **and** supporting document to:

AmeriHealth Caritas Next
Consent Processing Center
P.O. Box 7092
London, KY 40742-7092

Questions? Call Member Services at **1-833-282-2252 (TTY 711)**.