

Enclosure: HMSA Authorized Representative Form (optional)

The enclosed Authorized Representative Form is used to tell us which family members or friends you authorize us to share your information with. The individual or organization you list in part C of this form may contact HMSA on your behalf regarding your eligibility, billing, payment status, claims, and medical information HMSA uses to make payment decisions.

Please note that once your information is disclosed to the person or organization you indicate in part C of this form, the information in their possession may no longer be protected by privacy laws. This form may only be signed by you.

Please return your completed Authorized Representative form to RCUH as soon as possible.

Part A - Member information

- Last Name – Enter legal last name as it appears on your HMSA membership card.
- First Name – Enter legal first name as it appears on your HMSA membership card.
- MI – Enter middle initial(s).
- Address – Enter street address (e.g., “123 Any Street”).
- City – Enter name of the city (e.g., “Honolulu”).
- State – Enter state abbreviation (e.g., “HI”).
- ZIP Code – Enter five-digit ZIP code. If known, include ZIP +4.
- Email – Enter an email address, if available.
- Home Phone – Enter a home telephone number with area code.
- Cell Phone – Enter a cell phone number with area code.
- HMSA Subscriber Number(s) – Please include the HMSA subscriber number(s) as indicated on your HMSA membership card.
- Birth Date – Enter the birth date in the format mm/dd/yyyy (e.g., 07/15/1990).

Part B - Request type

Select one of the following two options. Only one selection should be chosen per form.

1. New Request – Select this option if you’re appointing a new authorized representative to act on your behalf.
2. Update an Existing Request – Select this option if you’re modifying information about your current authorized representative (e.g., adding or changing the limitations to the authorized representative’s authority, or modifying the expiration date for the personal representative to act on your behalf).

Part C - Information on authorized representative(s):

Complete all information about the individual or organization that will represent you and make requests on your behalf. You may enter information for two individuals or organizations to act on your behalf.

- Name of Person or Organization – State the legal first and last name of a person or the name of an organization you want appointed as your authorized representative. If indicating an organization, include a specific individual within the organization that will represent you and act on your behalf, if possible.
- Relationship to Member – Indicate the relationship between you and your authorized representative (e.g., spouse, daughter-in-law, attorney, etc.).
- Telephone # or Last four digits of Social Security Number – The information will be used to verify the authorized representative’s identity when they contact HMSA on your behalf.

Part D - Appointment limitations and expiration:

- Authorization Limitations – Unless specified in part D of this form, your authorized personal representative will have full access to all of your information. If you would like to limit the information your authorized representative may access, indicate so by placing a checkmark in each category of information to restrict. Please note that your authorized representative won’t have access to the categories of information you indicate with a checkmark. Leaving this section blank implies no limitations are desired.
- Expiration – This authorization will be effective beginning on the date it was signed by you and will expire on the earliest of the following dates:
 - Five years from the date the form was signed.
 - A date specified by you (and less than five years).
 - A specific event as described you (which occurs in less than five years from the date the form was signed).
 - Eighteen months after your benefit coverage with HMSA terminates.

Part E - Your individual rights

This section of the form describes your rights as indicated by applicable state and/or federal laws.

Part F - Signature

Sign at the bottom of the form.

AUTHORIZED REPRESENTATIVE FORM



An Independent Licensee of the Blue Cross and Blue Shield Association

COMPLETE THIS FORM TO AUTHORIZE FAMILY AND FRIENDS TO CONTACT HMSA ON YOUR BEHALF
ALL SECTIONS MUST BE COMPLETED UNLESS OTHERWISE SPECIFIED

PART A: MEMBER INFORMATION

Last Name	First Name	MI	
Address	City	State	ZIP Code
Email	Home Phone # ()	Cell Phone # ()	
HMSA Subscriber Number(s) (Located on your membership card)		Birth Date __ / __ / ____	

PART B: REQUEST TYPE (Choose only one request per form)

- New Request** – This form is a request to assign a new authorized representative.
- Update an Existing Request** – This form is to modify (i.e., change the limitations on) a previously approved authorized representative.
- Revoke an Existing Request** – This form is to request termination of a previously approved authorized representative. Enter an effective date for the termination: __ / __ / ____.

PART C: INFORMATION on AUTHORIZED REPRESENTATIVE(S) (All data fields must be completed)

Name of Person or Organization	Relationship to Member	Drivers License # or last 4 digits of Social Security #
Name of Person or Organization	Relationship to Member	Drivers License # or last 4 digits of Social Security #

PART D: APPOINTMENT LIMITATIONS AND EXPIRATION

I understand that I have the right to limit the type of information that may be given to the authorized representative(s) named in Part C of this form. I further understand that by leaving this section blank, I am creating no limitation on the information that may be disclosed to the authorized representative(s).

Authorization Limitations: DO NOT DISCLOSE the type of information indicated below:

- | | | |
|--|---|---|
| <input type="checkbox"/> Claims & Payment | <input type="checkbox"/> Eligibility & Enrollment | <input type="checkbox"/> Dues Payment & Billing |
| <input type="checkbox"/> Referral & Preauthorization | <input type="checkbox"/> Medical Records | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Appeals | <input type="checkbox"/> Abortion/Family Planning |
| <input type="checkbox"/> Other: _____ | | <input type="checkbox"/> Alcohol/Substance Abuse |
- (Continued on next page)

AUTHORIZED REPRESENTATIVE FORM



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Expiration	<p>This appointment will expire five years from the date it was signed unless you specify a different date below:</p> <p><input type="checkbox"/> One year</p> <p><input type="checkbox"/> Three years</p> <p><input type="checkbox"/> Until: __/__/____ (must be less than five years)</p> <p><input type="checkbox"/> Event described here: _____ (must occur within five years)</p>
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PART E: YOUR INDIVIDUAL RIGHTS

I understand that (**please read**):

- This appointment is based on my own need and HMSA does not condition treatment, payment, enrollment, or eligibility for benefits on receiving this appointment.
- I may revoke this appointment at any time by giving HMSA five business days written notice to the address indicated below. If I revoke this appointment, it will not affect any action HMSA took prior to receiving my written notice.
- Once my protected health information is disclosed to the person or organization I specified in Part C of this form, the information in their possession may no longer be protected by privacy laws.
- This appointment does not allow an authorized representative to request HMSA to release my information to others.
- HMSA will not treat someone as your authorized representative if we have reason to believe: 1) You may be subject to domestic violence, abuse, or neglect by the authorized representative; 2) Treating the person as your authorized representative could endanger you; or 3) In the exercise of professional judgment (for example, in a licensed professional's judgment) HMSA decides that it is not in your best interest to treat the person as your authorized representative.
- This request will expire at date specified in Part D of this form, upon revocation, or 18 months after my benefits coverage has terminated.
- I may request a copy of this signed form.
- If I have questions about this form, I may contact HMSA at (808) 948-6111 on Oahu.

PART F: SIGNATURE

I, (print member's name) _____, have had full opportunity to read and understand the contents of this form. I hereby release Hawaii Medical Service Association from all legal responsibility of liability that may arise from my appointment of the authorized representative(s). **I understand that, by signing this form, I am authorizing HMSA to allow my authorized representative(s) to act on my behalf as described above.**

Member/Authorized Signature: _____ **Date:** __/__/____

If signed by other than the member or parent of minor child, please print your name below and indicate your relationship. Provide a copy of verification of your legal right (e.g., power of attorney documentation) to make this authorization.

Authorized Representative Name: _____

Relationship to Member: _____

**INCOMPLETE FORMS WILL NOT BE PROCESSED
ALL FIELDS ARE REQUIRED UNLESS OTHERWISE SPECIFIED**

Please complete, sign, and submit this form to:
HMSA Privacy Office, P.O. Box 860, Honolulu, HI 96808-0860, (fax) 952-7580