CENTRAL HEALTH MEDICARE PLAN

Personal Representative Request (last updated 03/17/2023)

The purpose of implementing a Personal Representative is to enable another individual to act on your behalf with respect to:
• making decisions about your health benefits,
• requesting and/or disclosing your private health information, and
• exercising all of the rights you have under your health benefit plan.

A Personal Representative may either be legally appointed, or designated by a Member/Participant to act on his or her behalf:
• When a Personal Representative has been legally appointed, the Personal Representative should complete and sign this form. Supporting legal documentation, such as a power-of-attorney that indicates full health care decision-making authority or conservatorship papers, must be submitted with this form.
• When a Personal Representative is being designated by a Member/Participant, the Member/Participant needs to sign this form in the presence of a Notary Public.

Important: If medications and communications are to be sent to the Personal Representative, please call Central Health Medicare Plan (CHMP) at 1-866-314-2427. TTY users should call 711. We are open seven days a week from 8:00 AM – 8:00 PM (PST).

The Member/Participant retains his or her right to act on his or her own behalf unless CHMP receives legal documentation dictating otherwise.

Note: If your request is granted, it will affect only written and oral communications from CHMP. If you also wish your physician or anyone outside of CHMP to make this change, you must obtain their agreement separately.

VERIFICATION– (Please Print)
Identification of Member/Participant:
(The following information is needed for verification.)
Name of Member: _____ Date of Birth: _____
Phone Number where we can reach you if we need to contact you to process your request (required): _____
Social Security #: _____
Member ID card number (if applicable): _____

Identification of Personal Representative:
Name of Personal Representative: (only one person can be named): _____
Relationship to Member/Participant: _____
Date of Birth of Personal Representative: (answer in the following 8-digit format: 11231949 for November 23, 1949) ___ ___ ___ ___ ___ ___ ___ ___

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Address where communications about this Member/Participant should be sent:

_____

_____

What is the reason for this request? _____

VERIFICATION QUESTIONS FOR PERSONAL REPRESENTATIVE
(In this section "You" and Your" refer to the Personal Representative.)

The answers you provide below will be used to verify your identity if you call for private health information about the Member/Participant. Note that we ask these questions because the answers should be easy for you to remember, but you may enter other numbers as described below.

What is your mother's date of birth? (answer in the following 8-digit format: 11231949 for November 23, 1949) ___ ___ ___ ___ ___ ___ ___ ___

• Please DO NOT provide anyone else with the answers to these questions.
• You should keep a copy of this form for reference.

PLEASE NOTE

• If the information on this form is not complete, CHMP will return the form to you, and this request will not be considered until CHMP receives complete information.
• If your Member ID or date of birth is changed, another form will need to be completed at that time.
• If either the Member/Participant or Group changes to a different type of health care benefits coverage provided by CHMP, another form will need to be completed at that time.
• Any previous request to send information to an alternate address will be disregarded. All future Member/Participant correspondence will be sent to the address specified above.
• You may change or revoke this request by sending a written request to CHMP at the address on the following page. You can obtain a Change/Revoke form by calling CHMP Member Services at the number on your CHMP ID card.

SIGNATURE

Personal Representatives who are appointed by a court order or other legal documentation, ***please complete section A.***
Personal Representatives who are designated by a Member/Participant, ***please proceed to sections B and/or C.***

A. Personal Representatives who are legally appointed:

I have read and understand the above information. I acknowledge that by signing this form I have the legal authority to act on behalf of the Member/Participant.
Signature of Personal Representative: _____ **Date:** _____
To safeguard privacy and help make sure no one other than the person whom the Member/Participant designates receives Private Health Information, this request must be submitted with appropriate supporting legal documentation.

B. Personal Representatives designated by a Member/Participant

To safeguard privacy and help make sure no one other than the person whom the Member/Participant designates receives Private Health Information, this request must be signed by the Member/Participant and be notarized. (Notary services often can be provided free at a bank where you have an account).
I have read and understand the above information. I acknowledge that by signing this form I authorize CHMP to treat my Personal Representative as myself.

Signature of Member/Participant/Parent/Guardian *(This line is for the Member/Participant to sign, authorizing the Personal Representative.)*

_____**Date:** _____

C. Notary Public Signature

State of)
) ss.
County of)

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

On this the _____ day of _____, 20_____, before me, (Notary Public), the undersigned officer, personally appeared _____(Member/Participant), known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument and acknowledges that (s)he executed the same for the purposes therein contained. In witness whereof I hereunto set my hand.

_____

Notary Public *My Commission Expires*

Please Return This Completed Form To:

Central Health Medicare Plan
PO Box 14244
Orange, CA 92863
Phone# (866) 314-2427
Fax# (626) 388-2361