Braven HEALTH

RESET

Request for Appointment of Legal Personal Representative for Member

Use this form to let another person handle your health care needs which includes allowing full access to your personal health information, changes to your health care coverage, as well as receiving your health care mail. Read instructions on PAGE 2 before completing this form. ALL FIELDS MUST BE COMPLETED.

A separate form is required for each member on the policy. Please print legibly, except where signature is required.

This form applies to all Braven Health-issued products.

Please complete the information below, sign in the space provided and return to: Braven Health, Attn: HIPAA Team, P.O. Box 1458, Newark, New Jersey 07101-1458 or via fax at 973-274-2358.

Member's Information

Name (☐ *Subscriber* ☐ *Dependent*): _____

Subscriber Identification #: | | | | | | | | | | | | | | | |

Date of Birth: ____/____/____ (MM DD YYYY) Telephone #: ____-____-____

Address (on file): _____

City: _____ State: _____ ZIP: _____

I, _____ (*member*), hereby designate _____ (*legal personal representative*)

as my legal personal representative as it relates to communications from Braven Health and its business associates about my private information. I also understand that mental health and/or substance abuse private information may be disclosed, if I have utilized such services.

Documentation of Legal Authority to Act on Member's Behalf *(must submit at least one of the documents listed below)*

- **Power of attorney for health care, court order, guardianship, or conservatorship**
- **Health care proxy** (a document that legally allows another person to act on your behalf for health care decisions)
- **Executor or administrator of deceased member's estate**
- **Other–Describe the nature of your legal authority to make decisions concerning the member's health care**

_____

_____

Please attach the appropriate document(s) to the form.

Legal Personal Representative Information *(required for privacy verification purposes)*

Name (Last, First, MI): _____ Gender: ☐M ☐F ☐Undisclosed

Last 4 Digits of Social Security #: _____ Date of Birth: ____/____/____ (MM DD YYYY)

Address: _____

City: _____ State: _____ ZIP: _____

Telephone #: ____-____-____ Relationship to the member: _____

Note: All future correspondence such as EOB's, payment information, etc. will be sent to the Legal Personal Representative but will still be issued under the member's name.

Time Period for Representation: From: ____/____/____ (MM DD YYYY) To: ____/____/____ (MM DD YYYY)

NOTE: If no time period is provided, this request will remain in effect until the member or his/her legal personal representative notifies Braven Health in writing requesting a change or until the expiration date on the attached legal document.

☐Check here if you want your response to this request sent via email.

Email address: _____

Signature of ☐**Member** ☐**Requestor:** _____ Date: ____/____/____ (MM DD YYYY)
(check whether member or other requestor)

Printed Name: _____

INSTRUCTIONS

DOCUMENTATION OF LEGAL PERSONAL REPRESENTATIVE STATUS FOR MEMBER

(NOTE: This form cannot be used for a member's change of address. For member change of address, please contact Customer Service)

General Instructions: All fields are required to be completed unless otherwise specified.

Use this form if you wish to allow another individual as your legal personal representative regarding interactions with Braven Health. This form is intended to be used only to document a person who has the legal right to act your behalf and supporting legal documentation must be attached. All required legal documents will undergo a validation process by Braven Health's Privacy Office or its designee. A separate request form and documentation is required for each member on the coverage, even if authorizing the same representative.

Member Information Section:
This section requests information related to the member for which a legal personal representative is being requested. Since this information is used for both identification and verification purposes, the information included in this section should match the most current information for the member/subscriber that Braven Health's has on file. Please, be aware that this form may be denied if the information on the form does not match the information in our records.

Documentation of Legal Authority to Act on Member's Behalf Section:
This section should be completed to indicate the source of the legal personal representative's authority to act on member's behalf.

Legal Personal Representative Information Section:
The requested information in this section will be used by Braven Health for identification and verification purposes. The legal personal representative will be required to verify this information during a phone call if they wish to receive your personal health information.

Time Period of Representation: If no time period is provided, this request will remain in effect until the member or his/her legal personal representative notifies Braven Health in writing requesting a change or until the expiration date on the attached legal document.

Note: The appointment will be effective on the date that Braven Health processes and approves the form.

Mail this form to:

Braven Health
Attn: HIPAA Appeals Unit
PO Box 1458
Newark, NJ 07101-1458

Or Fax to: (973) 274-2358