DENVER HEALTH MEDICAL PLAN INC.™

DENVER HEALTH MEDICAID CHOICE

# APPOINTMENT OF PERSONAL REPRESENTATIVE FORM

Denver Health Medical Plan, Inc. (DHMP) must follow certain procedures before it may provide access to your Protected Health Information (PHI) to someone other than the Member. The purpose of appointing a Personal Representative is to enable another individual to act on your behalf with respect to: 1) making decisions about your health benefits; 2) requesting and/or disclosing your Protected Health Information; and 3) exercising some or all of the rights you have under your health insurance benefit plan. A Personal Representative may be legally appointed or designated by a Member to act on his/her behalf. Designating a Personal Representative is voluntary and can be a family member, friend, advocate, lawyer or an unrelated party. You may change or revoke the appointment of a Personal Representative at any time. If you choose to revoke an appointment, please complete Section H below and return to DHMP.

| **SECTION A: MEMBER INFORMATION** | | |
|---|---|---|
| **Member Name:** (Last, First, Middle Initial) | **Date of Birth:**<br>\| \| | **Telephone #:**<br>( ) - |
| **Address:** | **Group #:** (as shown on the Member's ID Card) | |
| **City, State, Zip:** | **Member ID #:** (as shown on the Member's ID Card) | |

| **SECTION B: PERSONAL REPRESENTATIVE INFORMATION** | | |
|---|---|---|
| **Name:** (Last, First, Middle Initial) | **Date of Birth:**<br>\| \| | **Telephone #:**<br>( ) - |
| **Address:** | **City, State, Zip:** | |

## SECTION C: PERSONAL REPRESENTATIVE'S RELATIONSHIP TO MEMBER

Please describe your relationship to the member:

_____

_____

_____

## SECTION D: TYPE OF INFORMATION TO BE DISCLOSED/USED/RECEIVED BY THE PERSONAL REPRESENTATIVE (select all that apply)

- ◯ Prior Authorization/Referral Info
- ◯ Case Management
- ◯ Member ID Card
- ◯ Premium Invoices
- ◯ Plan Documents (e.g., Member ID Card, Member Handbook, Explanation of Benefits)
- ◯ Enrollment/Benefits
- ◯ Pharmacy Information
- ◯ Claims
- ◯ Grievance and Appeals
- ◯ All documents and information available, without limitation
- ◯ Other: _____

## SECTION E: PLEASE RETURN THIS COMPLETED FORM AND ALL SUPPORTING DOCUMENTATION TO THE FOLLOWING MAILING ADDRESS OR FAX NUMBER

**Mailing Address:**
Denver Health Medical Plan, Inc.
Attn: Health Plan Services
938 Bannock Street, MC 6000
Denver, CO 80204

**Secured Fax #:**
303-602-2138

## SECTION F: MEMBER SIGNATURE:

I have completed the above information. I acknowledge that by signing this form I authorize DHMP to treat my Personal Representative as myself.

_____ _____

**Signature of Member** **Date**

## SECTION G: PERSONAL REPRESENTATIVE'S ACCEPTANCE OF APPOINTMENT

I,_____hereby accept the Member's appointment. I acknowledge that by signing this form I have authority to act on behalf of the Member. I certify that the information on this Personal Representative form is true, correct and accurate to the best of my knowledge. I understand that the Company may request information, now or in the future, as it deems necessary to confirm my Personal Representative status.

_____ _____

**Signature of Personal Representative** **Date**

**IMPORTANT NOTE:** The appointment of a Personal Representative is valid for one year from the member signature date. You may revoke the appointment at any time by completing the revocation section (Section H) and returning it to DHMP at the address provided.

## SECTION H: REVOCATION OF APPOINTMENT OF PERSONAL REPRESENTATIVE

I understand that by signing this section I am **revoking** my appointment of Personal Representation and no longer want the individual, (print individual's name legibly below),

_____

to act as my Personal Representative. I understand that this revocation applies to any future disclosures of Personal Health Information, whether verbal or written, and any future actions. I further understand that any disclosures or actions already taken by the Personal Representative and/or DHMP during the appointment of representation time period cannot be revoked. The revocation date that will be used is the date DHMP receives this revocation form.

_____ _____

**Signature of Member**

**Please mail or fax form to:**
Denver Health Medical Plan, Inc.
Attn: Health Plan Services
938 Bannock Street, MC 6000
Denver, CO 80204
Fax: 303-602-2138