

Personal Representative Request Form

Please print clearly in blue or black ink.

This form will need to be completely filled out for it to be processed. This includes attaching legal documentation (see page 2).

This form allows another person to make health care decisions for an AmeriHealth Caritas Next member. This person must have legal authority to act on your behalf. This includes legal guardianship or health care power of attorney. If you have questions, you can call Member Services at **1-833-590-3300 (TTY 711)**.

| Member information | | |
|---|---|------------------|
| First name: | Middle initial: | Last name: |
| Member ID number: | Date of birth (MM/DD/YYYY): □/□/□□□□ | |
| 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) □/□/□□□□ | |

Please keep a copy of this form for your records.



**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 documentation you are attaching:

- | | |
|--|--|
| <input type="checkbox"/> Power of attorney for health care decisions | <input type="checkbox"/> Other (please specify): |
| <input type="checkbox"/> Legal guardianship | |
| <input type="checkbox"/> Custodial order | |
| <input type="checkbox"/> Executor of estate | |

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 procedures 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 upon receipt of documentation supporting their legal authority to make health-related 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.

This is what you need to know:

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 completely filled out for it to be processed. This includes attaching legal documentation.

AmeriHealth Caritas Next will not, however, 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 endanger you; or (3) in the exercise of professional judgment (for example, in a licensed professional's judgment), AmeriHealth Caritas Next decides that it is not in your best interest to treat the person as your personal representative.

This is what you need to know:

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 an applicable law revokes it.

This is what you need to know:

If you allow for a personal representative, this document will remain effective until it is canceled. You can cancel this if you want to. You just have to tell us. A court order or other laws can also cancel it.

To assist AmeriHealth Caritas Next in responding to this request, please complete this form by printing or typing into the spaces provided. Attach additional pages if necessary to clarify your request. Attach a copy of the document supporting your personal representative's legal authority to act on your behalf.

This is what you need to know:

This form will need to be completely filled out for it to be processed. This includes attaching legal documentation. You may use additional pieces of paper if you need more space to write.

Mail the completed form and supporting documentation to:

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

Questions? Call Member Services at
1-833-590-3300 (TTY 711).



AmeriHealth Caritas
Next

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Notice of Nondiscrimination

AmeriHealth Caritas Next complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender identity or expression, or sexual orientation. AmeriHealth Caritas Next provides free aids and services to people with disabilities to communicate effectively with us, such as, qualified sign language interpreters and written information in other formats. If you need these services, contact the Member Services number on the back of your card. If you believe that AmeriHealth Caritas Next has failed to provide these services or discriminated in another way, you can file a grievance with AmeriHealth Caritas Next Attention: Member Grievances, P.O. Box 7430, London, KY 40742-7430, or fax: **1-833-356-7329**.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building Washington, DC 20201, phone: **1-800-368-1019**, TTY: **1-800-537-7697**, Complaint forms are available at <https://www.hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf>.

We speak your language

We provide free language services and information to people whose primary language is not English. To talk to an interpreter, call the Member Services number on the back of your card.

Ofrecemos servicios lingüísticos e información sin cargo a las personas cuya lengua materna no es el inglés. Para hablar con un intérprete, llame al número de Servicios al Miembro que figura en el dorso de su tarjeta.

我们为母语非英语的人士提供免费的语言服务及信息。如需与翻译交谈，请拨打您的会员卡背面的会员服务部电话。

Nou bay sèvis ak enfòmasyon gratis pou ede w nan lang pa w si se pa anglè ki lang prensipal ou. Pou pale avèk yon entèprèt, rele nimewo ekip sèvis pou manm yo ki nan do kat ou a.

અમે એવા લોકોને નિ:શુલ્ક ભાષા સેવાઓ અને માહિતી પ્રદાન કરીએ છીએ જેમની પ્રાથમિક ભાષા અંગ્રેજી નથી. દુભાષિયા સાથે વાત કરવા માટે, તમારા કાર્ડની પાછળ આપેલ સભ્ય સેવા નંબર પર કોલ કરો.

Nous fournissons gratuitement des services linguistiques et des informations à ceux dont la langue principale n'est pas l'anglais. Pour communiquer avec un interprète, appelez l'équipe service aux adhérents au numéro indiqué au dos de votre carte.

영어가 주 언어가 아닌 사람들을 위해 무료로 언어 서비스와 정보를 제공합니다. 통역사와 대화하려면 가입자 카드 뒷면에 기재된 가입자 서비스 번호로 연락하십시오.

Offriamo servizi linguistici e informazioni gratuiti per individui la cui lingua principale non è l'inglese. Per parlare con un interprete, chiami il numero dei Servizi per i membri sul retro della sua tessera.

Chúng tôi cung cấp thông tin và các dịch vụ ngôn ngữ miễn phí cho những người có ngôn ngữ chính không phải là tiếng Anh. Để nói chuyện với thông dịch viên, hãy gọi đến số điện thoại của Dịch Vụ Hội Viên ở mặt sau thẻ của quý vị.

Wir bieten Menschen, deren Muttersprache nicht Englisch ist, kostenlose Sprachdienste und Informationen an. Wenn Sie mit einem Dolmetscher oder einer Dolmetscherin sprechen möchten, rufen Sie bitte die Nummer des Mitgliederservice auf der Rückseite Ihrer Karte an.



Nagkakaloob kami ng mga libreng serbisyo sa wika at impormasyon sa mga indibidwal na ang pangunahing wika ay hindi Ingles. Upang makipag-usap sa isang interpreter, tumawag sa numero ng Member Services sa likod ng iyong card.

हम उन लोगों को मुफ्त भाषा सेवाएं और जानकारी प्रदान करते हैं जिनकी प्राथमिक भाषा अंग्रेजी नहीं है। दुभाषिए से बात करने के लिए, अपने कार्ड के पीछे सदस्य सेवाओं के नंबर पर कॉल करें।

ہم زبان کی خدمات اور معلومات ان لوگوں کو مفت فراہم کرتے ہیں جن کی بنیادی زبان انگریزی نہیں ہے۔ کسی مترجم سے بات کرنے کے لیے ممبر سروسز کے نمبر پر کال کریں جو آپ کے کارڈ کی پچھلی طرف درج ہے۔

نقدم خدمات ترجمة مجانية ومعلومات للأشخاص الذين لغتهم الأساسية ليست اللغة الإنجليزية. للتحدث مع مترجم، اتصل برقم خدمات الأعضاء الموجود على ظهر بطاقتك.

ప్రథమ భాష అంగ్లం కాని వారికి మేము ఉచిత భాషా సేవలు మరియు సమాచారాన్ని అందిస్తాము. వ్యాఖ్యాతతో మాట్లాడడానికి, మీ కార్డు వెనుకవైపు ఉన్న మెంబర్ సర్వీసెస్ నంబర్కు కాల్ చేయండి.

We bieden gratis taaldiensten en informatie aan mensen van wie de hoofdtal niet Engels is. Om met een tolk te spreken, belt u het nummer van Ledenservices op de achterkant van uw kaart.