

A product of AmeriHealth Caritas North Carolina, Inc.

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 **1-833-613-2262 (TTY 1-844-214-2471)**.

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:

- Power of attorney for health care decisions
- Legal guardianship
- Custodial order
- Executor of estate

Other (please specify):

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 **1-855-375-8811**

(TTY 1-866-209-6421).



AmeriHealth Caritas[™]

Next

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www.amerihealthcaritasnext.com

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: Appeals and Grievances, P.O. Box 7379, London, KY 40742 or fax: **1-844-201-6798**.

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: **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。

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.

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

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.

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

Peb muab kev pab cuam txhais lus pub dawb thiab cov ntaub ntawv rau cov neeg uas hom lus ib txwm hais tsis yog lus Askiv. Txhawm rau txuas lus nrog ib tus kws pab txhais lus, hu rau tus npawb xov tooj Pab Cuam Tswv Cuab nyob sab tom qab ntawm koj daim npav.

Мы предоставляем бесплатные языковые услуги и информацию людям, для которых английский не является родным. Чтобы обратиться к переводчику, позвоните по номеру, указанному на обратной стороне вашего удостоверения.

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.

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.



យើងផ្តល់ជូនសេវាកម្មភាសា និងព័ត៌មានដោយឥតគិតថ្លៃទៅដល់អ្នកដែលមានភាសាទីមួយមិនមែនជាភាសាអង់គ្លេស ។
ដើម្បីនិយាយជាមួយអ្នកបកប្រែផ្ទាល់មាត់ សូមហៅទៅលេខទូរស័ព្ទរបស់សេវាកម្មសមាជិកនៅខាងខ្នងនៃប័ណ្ណរបស់អ្នក ។

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.

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।

ພວກເຮົາໃຫ້ບໍລິການພາສາຟຣີແລະຂໍ້ມູນຂ່າວສານສໍາລັບຜູ້ທີ່ພາສາຂອງທ່ານບໍ່ແມ່ນພາສາອັງກິດ.
ເພື່ອໂອ້ນລັກບາຍພາສາ, ໃຫ້ໂທຫາເບີບໍລິການສະມາຊິກຢູ່ດ້ານຫຼັງບັດຂອງທ່ານ.

英語を母国語としない人々に、無料の言語サービスと情報を提供しています。通訳者と話すには、カード裏面に記載されているメンバーサービス番号に電話してください。