Horizon NJ Health

Request for Personal Representative

Instructions: To request a personal representative, please complete the information below, sign in the space provided and return to: **Horizon NJ Health**, 250 Century Pkwy, Mt. Laurel, NJ 08054 or via fax at **1-609-538-1574**. A separate form is requires for each member on the policy or coverage, as applicable. Please print legibly.

Member Information: (circle whether request is for subscriber or dependent)

Name (❑ Subscriber ❑ Dependent): ______________________________

Subscriber Identification #: ______________________________

Date of Birth: _____ / _____ / ________ Telephone #: _______ - _______ - _____________
MM DD YYYY

Address: ______________________________

City: ______________________ State: ____________ ZIP: _____________

I, ______________________________, hereby appoint ______________________________ to be
(member) **(personal representative)**
designated as my personal representative. I understand this request applies to communications from Horizon NJ 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.

Time Period for Representation: From: _____ / _____ / ________ To: _____ / _____ / ________
MM DD YYYY MM DD YYYY

NOTE: If no time period is provided, this request will remain in effect until the member or his her legal representative notifies Horizon NJ Health in writing requesting a change.

Purpose of Representation: (select one)

❑ **Mental Health/Substance Abuse Consent:** If you have an automatic designated personal representative and you want that individual to have access to your mental health and substanceabuse information, please check this box.

❑ **Account Inquiries Only:** This means that Horizon NJ Health is allowed to disclose private information to the individual selected. This individual would have access to information such as:claims, enrollment, premiums, appeals, etc. (Default if no selection is made)

❑ **Correspondence & Account Inquiries:** Not only can Horizon NJ Health disclose private information to the individual selected, but he/she will receive all correspondence that would normally go to the member, including EOBs, checks, etc. For that reason, this option should ONLY be chosen if the member is sure he/she no longer wants to receive relevant coverage information directly, since the personal representative will receive it instead (generally, only in circumstances of incapacity or incompetence (adults), or in the representation of a child; typically not for spouse-to-spouse representation).

Continued on Back

Personal Representative Information: (required for privacy verification purposes)

Name (Last, First, MI): ____

Last 4 Digits of Social Security #: ____________________ Date of Birth: _____ / _____ / _______

MM DD YYYY

Address: ____

City: ____ State: ________ ZIP: ___________

Telephone #:______ - ______ - _________ Relationship to the member: ____________________

NOTE: If the representative is court-ordered or has another legal designation (examples: power of attorney, living will, executor or administrator of probate estate), you must attach/include copy of the official document(s) if not already provided. If you are a documented legal representative, you may make this Request and sign this form below on behalf of the member.

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

Email address: _______________________________

Signature of ❑ Member ❑ Requestor: ___________________ Date: _____ / _____ / ______

(*check whether member or other requestor*) MM DD YYYY

Printed Name: ____

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