

A representative is someone a Prescription Advantage applicant/member appoints to have access to his/her Protected Health Information (PHI). Protected Health Information may include enrollment, eligibility, billing, or prescription drug claims information. Carefully review the representative descriptions before you make your choice(s).

If you and your spouse want to appoint different representatives, separate forms must be used. If you and your spouse want to appoint the same person, you may use one form and you both must sign the form. In all cases, the representative must sign the form.

### **What is an Authorized Representative?**

An Authorized Representative (AR) is a person designated to make decisions for you regarding your Prescription Advantage benefits. For example, your Authorized Representative may submit a request to terminate your membership. In addition, all written and verbal communication from Prescription Advantage will be with your representative.

When you name an Authorized Representative, you understand that:

- This designation covers your Protected Health Information, including enrollment, eligibility, billing, and prescription drug claims information;
- The designation continues even if your membership is denied or terminated for any reason unless you cancel or change it. You may do so at any time by sending a letter to Prescription Advantage;
- Prescription Advantage cannot take back any information that has already been released;
- Once Prescription Advantage releases information to your representative, it may no longer be protected by privacy law, and your representative may give it out again;
- Designating, changing, or removing an Authorized Representative has no impact on your eligibility for Prescription Advantage benefits.

If you have any questions, please call Prescription Advantage Customer Service at 1-800-243-4636, or TTY for the deaf and hard of hearing at 1-877-610-0241.

### **What is a Release of Information Designee?**

A Release of Information designee is someone you allow to contact Prescription Advantage about your membership. We may share information regarding your eligibility, enrollment, and/or drug purchases with this person, however he/she cannot make any decisions for you concerning Prescription Advantage. All communication will continue to be with you. This designation continues even if your Prescription Advantage membership is denied or terminated for any reason unless you cancel or change it by sending a letter to Prescription Advantage.

### **What is a Temporary Authorized Representative?**

A Temporary Authorized Representative is a person you allow to discuss your application, its contents, and required documentation. An example is a person, such as a family member or advocate, who helped you complete the Prescription Advantage application, and you prefer that we contact with any questions or need more information.

A Temporary Authorization is only valid during the application process and ends once a final eligibility decision is made. If you are approved for benefits, your Temporary Authorized Representative can continue to contact us for 30 calendar days after your benefit effective date. If you are denied, he/she can contact us for 30 calendar days after the date on the denial notification letter. In addition, once an eligibility decision is made, all written and verbal communication will be directly with you.

### **How to Name a Representative**

Complete the information found on the reverse side for the type of representative you prefer. You may only have one Authorized Representative but you may have more than one Release of Information designee. You and your representative(s) must sign the form(s) where indicated. Your spouse must sign if he/she chooses the same representative(s). Mail or fax this form to:

**Prescription Advantage**  
**PO Box 15153**  
**Worcester, MA 01615-0153**  
**Fax: 508-793-1133**

**Complete this section to name an Authorized Representative**

I (We) designate the following person as my (our) Authorized Representative. Prescription Advantage may release my (our) Protected Health Information to him/her. I (We) understand the responsibilities of an Authorized Representative as described on the other side of this form.

Applicant/Member Name	Spouse Name	Telephone Number	
Authorized Representative Name (please print)		Telephone Number	
Authorized Representative Address	City	State	Zip Code
X _____ Date: _____ Applicant/Member Signature (or designee if applicant/member is unable to complete the form)			
X _____ Date: _____ Spouse Signature (or designee if spouse is unable to complete the form)			
X _____ Date: _____ Authorized Representative Signature			

**Complete this section to name a Release of Information Designee**

I (We) allow the following person to inquire/receive information regarding my (our) Prescription Advantage benefits. Prescription Advantage may discuss my (our) eligibility, enrollment, and/or prescription drug purchases with him/her. I (We) understand the responsibilities of a Release of Information designee as described on the other side of this form.

Applicant/Member Name	Spouse Name	Telephone Number	
Release of Information Designee Name (please print)		Telephone Number	
X _____ Date: _____ Applicant/Member Signature (or designee if applicant/member is unable to complete the form)			
X _____ Date: _____ Spouse Signature (or designee if spouse is unable to complete the form)			
X _____ Date: _____ Release of Information Designee Signature			

**Complete this section to name a Temporary Authorized Representative**

I (We) designate the following person to be my (our) Temporary Authorized Representative. Prescription Advantage may discuss my (our) application, its contents, and required documentation with my (our) designee. I (We) understand the responsibilities of a Temporary Authorized Representative as described on the other side of this form.

Applicant/Member Name	Spouse Name	Telephone Number	
Temporary Authorized Representative (please print)		Telephone Number	
Temporary Authorized Representative Address	City	State	Zip Code
X _____ Date: _____ Applicant/Member Signature (or designee if applicant/member is unable to complete the form)			
X _____ Date: _____ Spouse Signature (or designee if spouse is unable to complete the form)			
X _____ Date: _____ Temporary Authorized Representative Signature			