DENVER HEALTH
Medical Plan, Inc.

Health First COLORADO
Colorado's Medicaid Program

Administered by Denver Health Medicaid Choice

Appointment of Personal Representative Form

Denver Health Medical Plan, Inc. and Denver Health Medicaid Choice ("the Company") 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 the Company.

Section A: Member/Subscriber Information		
Member Name: (First, Middle Initial, Last)	**Date of Birth:** / /	**Telephone Number:** ( )
Address:	**City, State, ZIP**	
Member ID Number:	**Group #:** (as shown on the member's ID card)	
Subscriber Name (if different from Member):	**Date of Birth:** / /	**Telephone Number:** ( )

Section B: Personal Representative Information		
Member Name: (First, Middle Initial, Last)	**Date of Birth:** / /	**Telephone Number:** ( )
Address:	**City, State, ZIP**	
Personal Rep Mother's Maiden Name: (will be used for identity verification)	**Last 4 digits of Social Security No.**	

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Section C: Personal Representative's Relationship to Member: (Select one)

☐ Parent/guardian of a minor – Attach a copy of the minor's birth certificate or proof of guardianship.

☐ Power of attorney with authority to make health care decisions on behalf of a member – Attach copy of signed power of attorney form.

☐ Executor or administrator of the deceased member's estate – Attach Letters Testamentary or other legal documents evidencing executor or administrator status.

☐ Other (please describe your relationship to the member, and attach proof of your authority to make health care decisions on behalf of the member).

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Section D: Type of Information to be Disclosed/Used/ Received by the Personal Representative: (please select all that apply)

☐ Prior Authorization/ Referral Info ☐ Enrollment/Benefits ☐ Claims

☐ Case Management ☐ Pharmacy Information ☐ Grievance and Appeals

☐ Member ID Card ☐ Premium Invoices ☐ Other ______________________________

☐ Plan Documents (e.g. Member ID Card, Member Handbook and Explanation of Benefits)

☐ All documents and information available, without limitation

Section E: Please Return this Completed Form and All Supporting Documentation To:

Mail:
Denver Health Medical Plan, Inc.
ATTN: Compliance Department
938 Bannock Street, Mail Code 6000
Denver, CO 80204

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Section F: Member/Subscriber's Signature:

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

_______________________________________ _______________________

Signature of Member/Subscriber **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 have attached the required documentation, where applicable, to establish my status as the Personal Representative. 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 MESSAGE: 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 the Company at the address provided.

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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),

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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 the Company during the appointment of representation time period cannot be revoked. The revocation date that will be used is the date the Company receives this revocation form.

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Signature of Member/Subscriber **Date**

Please send mail form to:

Denver Health Medical Plan, Inc.
ATTN: Compliance Department
938 Bannock Street, Mail Code 6000
Denver, Colorado 80204