INTEGRITY HOME CARE + HOSPICE MEDICAL PLAN

MEMBER'S AUTHORIZATION REQUEST FORM

You may give Mercy Benefit Administrators written authorization to disclosure your protected health information (PHI) to anyone that you designate and for any purpose. If you wish to authorize a person or entity to receive your PHI, please complete the information below. **Completion of this form will not change the way that Mercy Benefit Administrators communicates with members or subscribers. *For example*, we will send explanations of benefits (EOB) statements to the subscriber.**

Member's Name: **First** _____ **Middle Initial** _____

Last _____

Member's Date of Birth: _____ Member's Telephone #: _____

Subscriber's Full Name: _____

Subscriber's ID Number: *(from your ID card)* _____

At my request, I authorize Mercy Benefit Administrators to disclose my Protected Health Information to: *(enter name of person/entity who will receive your PHI):*

First Name _____ **Middle Initial** _____

Last _____

Relationship To Member: _____

Please provide the following information to the person you have authorized so that we may verify the person's identity and authority to receive your PHI: (1) your subscriber ID number, (2) your date of birth, and (3) subscriber address.

I authorize Mercy Benefit Administrators to disclose the following PHI to the person/entity listed above: **Check ALL boxes that apply.**

- ☐ Enrollment information
- ☐ Benefit information
- ☐ Premium payment information
- ☐ Explanation of Benefits (EOB) information
- ☐ All claims information
- ☐ ALL information requested
- ☐ All services from a specific health care provider (list provider's name):_____
- ☐ Other (please list specific PHI):_____

*OTHER SIDE MUST BE COMPLETED AND SIGNED BY MEMBER

If you want to authorize someone to have access to your mental health or substance abuse PHI, please call Mercy Benefit Administrators at 877-875-7700 (or 417-820-3825 Springfield, MO only) to request a separate form.

I would like this authorization
to expire on *(enter date)*: _____ **OR** ☐ When my policy expires.

I understand that I may revoke this authorization at anytime by giving Mercy Benefit Administrators written notice mailed to the address below. However, if I revoke this authorization, I also understand that the revocation will not affect any action Mercy Benefit Administrators took in reliance on this authorization before they received my written notice of revocation.

I also understand that Mercy Benefit Administrators will not condition the provision of health plan benefits on this authorization.

I also understand that if the persons or entities I authorize to receive my PHI are not health plans, covered health care providers or health care clearinghouses subject to the Health Insurance Portability and Accountability Act (HIPAA) or other federal health information privacy laws, they may further disclose the PHI and it may no longer be protected by HIPAA or federal health information privacy laws.

Signature:_____**Date** _____

If signed by a personal representative:_____

PRINT YOUR FULL NAME

Describe your authority to act for the member (e.g. power of attorney, court order, parent of minor child, etc.):_____

NOTE: Please attach the legal document naming you as the personal representative if you have not previously submitted it to us.

NOTE: Mercy Benefit Administrators will consider the effective date of this authorization to be the date it enters this authorization into its Commercial Operations business system, typically 5 days following receipt.

If you would like this authorization to become effective on a date after Mercy Benefit Administrators enters the authorization into its system, please enter the date here:

_____

MONTH DAY YEAR

RETURN THIS AUTHORIZATION TO:

Mercy Benefit Administrators
PO BOX 14230
SPRINGFIELD. MO 65814