Horizon Blue Cross Blue Shield of New Jersey

Request for Personal Representative

Instructions: To request a personal representative, please complete the information below, sign in the space provided and return to: Horizon Blue Cross Blue Shield of New Jersey, Centralized Correspondence Unit, Attn: HIPAA Unit, P.O. Box 820, Newark, New Jersey 07101-0820. A separate form is required 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):* _____

Policy Identification #: _____

Date of Birth: _____/_____/_____ Telephone #: _____

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 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: _____/_____/_____

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

Purpose of Representation: *(select one)*

____ **Account Inquiries Only:** This means that Horizon BCBSNJ is allowed to disclose private information to the individual selected. This individual would have access to information such as: claims, enrollment, premiums, appeals, etc.

____ **Correspondence & Account Inquiries:** Not only can Horizon BCBSNJ 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).

Personal Representative Information: (required for privacy verification purposes)

Name (Last, First, MI): _____

Social Security # (Last 4 Digits **only**): _____ Date of Birth: _____/_____/_____

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.

Signature of Member / Requestor: _____Date: _____/_____/_____
(circle whether member or other requestor)

Printed Name: _____