Horizon
Horizon NJ Health

Reset

Request for Appointment of Legal Representative for Member

Use this form to let another person handle your health care needs which includes allowing full access to your personal health information, changes to your health care coverage, as well as receiving your health care mail. Read instructions on PAGE 2 before completing this form. ALL FIELDS MUST BE COMPLETED.

A separate form is required for each member on the policy. Please print legibly, except where signature is required.

Please complete the information below, sign in the space provided and return to Horizon NJ Health, Attn: HIPAA Team, 1700 American Blvd., Pennington, NJ 08534 in the stamped envelope enclosed.

Member's Information

Name (☐ *Subscriber(Member)* ☐ *Dependent):* _____

Subscriber (Member) Identification #: _____

Date of Birth: ____/____/____ (MM / DD / YYYY) Telephone #: ____-____-____

Address (on file): _____

City: _____ State: _____ ZIP: _____

I, _____ *(member)*, hereby designate _____ *(legal representative)*
as my legal representative as it relates to communications from Horizon NJ Health and its business associates about my private information. I also understand that mental health and/or substance use disorder private information may be disclosed, if I have utilized such services.

Documentation of Legal Authority to Act on Member's Behalf *(must submit at least one of the documents listed below)*

- **Power of attorney for health care, court order, guardianship, or conservatorship**
- **Health care proxy** (a document that legally allows another person to act on your behalf for healthcare decisions)
- **Executor or administrator of deceased member's estate**
- **Other–Describe the nature of your legal authority to make decisions concerning the member's health care**

_____

_____

Please attach the appropriate document(s) to the form.

Legal 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: All future correspondence such as Explanation of Benefits (EOB), payment information, etc. will be sent to the Legal Representative but will still be issued under the member's name.

Time Period for Representation: From: ____ / ____ / ____ (MM / DD / YYYY) To: ____ / ____ / ____ (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 or until the expiration date on the attached legal document.

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

Email address: _____

Signature of ☐ **Member** ☐ **Requestor:** _____ Date: ____/____/____ (MM / DD / YYYY)
(check whether member or other requestor)

Printed Name: _____

INSTRUCTIONS
DOCUMENTATION OF LEGAL REPRESENTATIVE STATUS FOR MEMBER

(NOTE: This form cannot be used for a member's change of address. For member change of address, please contact Member Services)

General Instructions: All fields are required to be completed unless otherwise specified.

Use this form if you wish to allow another individual as your legal representative regarding interactions with Horizon NJ Health. This form is intended to be used only to document a person who has the legal right to act on your behalf and supporting legal documentation must be attached. All required legal documents will undergo a validation process by Horizon NJ Health's Privacy Center of Excellence or its designee. A separate request form and documentation is required for each member on the coverage, even if authorizing the same representative.

Member Information Section:
This section requests information related to the member for which a legal representative is being requested.
Since this information is used for both identification and verification purposes, the information included in this section should match the most current information for the member/subscriber that Horizon NJ Health has on file.
Please be aware that this form may be denied if the information on the form does not match the information in our records.

Documentation of Legal Authority to Act on Member's Behalf Section:
This section should be completed to indicate the source of the legal representative's authority to act on member's behalf.

Legal Representative Information Section:
The requested information in this section will be used by Horizon NJ Health for identification and verification purposes. The legal representative will be required to verify this information during a phone call if they wish to receive your personal health information.

Time Period of Representation: 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 or until the expiration date on the attached legal document.

Note: The appointment will be effective on the date that Horizon NJ Health processes and approves the form.

Mail this form to:

Horizon NJ Health
Attn: HIPAA Team
1700 American Blvd.
Pennington, NJ 08534

Or fax to: (609) 538-1574

HNJH_HIPAA_Team@horizonblue.com

Horizon NJ Health

1700 American Blvd.
Pennington, NJ 08534
horizonNJhealth.com

Notice of Nondiscrimination

Horizon NJ Health complies with applicable Federal civil rights laws and does not discriminate against nor does it exclude people or treat them differently on the basis of race, color, gender, national origin, age, disability, pregnancy, gender identity, sex, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.

Horizon NJ Health provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information written in other languages.

Contacting Member Services
Please call Member Services at **1-800-682-9090** (TTY **711**) **or the phone number on the back of your member ID card**, if you need the free aids and services noted above and for **all other Member Services issues, including:**

- **Claim, benefits or enrollment inquiries**
- **Lost/stolen ID cards**
- **Address changes**
- **Any other inquiry related to your benefits or health plan**

Filing a Section 1557 Grievance
If you believe that Horizon BCBSNJ has failed to provide the free communication aids and services or discriminated on the basis of race, color, gender, national origin, age or disability you can file a discrimination complaint also known as a Section 1557 Grievance. Horizon BCBSNJ's Civil Rights Coordinator can be reached by calling the Member Services number on the back of your member ID card or by writing to the following address:

Horizon BCBSNJ – Civil Rights Coordinator
PO Box 10194
Newark, NJ 07101

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

Office for Civil Rights Headquarters
U.S. Department of Health and Human Services 200
Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019 or **1-800-537-7697** (TDD)

OCR Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

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