Horizon
Horizon NJ Health

Reset

Request for Appointment of Limited Representative for Member

Use this form if you wish to allow your personal health information to be disclosed to the person named below so they can assist you with your health care and payment for health care. This person will not be permitted to make policy changes. Read instructions on PAGE 3 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 acknowledge _____ (*limited representative*)

as my limited representative. I understand this request applies to communications from Horizon NJ Health and its business associates about my private information.

Information that Horizon NJ Health may disclose:

I authorize Horizon NJ Health to disclose the following information to my limited representative:

☐ Option 1: **All my information, including potentially sensitive information**. This may include a *diagnosis* (name of illness or condition), *procedure* (type of treatment), *claims, the name of my doctors* and *other health care providers*, and *financial information* (like billing and banking). Horizon NJ Health is permitted to disclose information related to HIV or AIDS, sexually transmitted disease, mental health, substance use disorders (including alcohol abuse), genetic information, and sexual health (family planning & contraception, abortion, and pregnancy).

Please note for certain behavioral health (mental health/substance use) disclosures, you may be required to provide additional authorizations.

☐ Option 2: **All my information, BUT NOT sensitive information**. For non-sensitive information, this may include a *diagnosis* (name of illness or condition), *procedure* (type of treatment), *claims, the name of my doctors* and *other health care providers*, and *financial information* (like billing and banking). However, Horizon NJ Health is NOT permitted to disclose this information related to HIV or AIDS, sexually transmitted disease, mental health, substance use disorders (including alcohol abuse), genetic information, and sexual health (family planning & contraception, abortion, and pregnancy).

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: _____

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 limited representative notifies Horizon NJ Health in writing requesting a change.

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

Email address: _____

I have read the contents of this form. I understand, agree, and allow Horizon NJ Health to discuss and/or disclose my information as I have stated above. I understand that Horizon NJ Health does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or eligibility benefits. I understand I am entitled to a copy of this form and agree that a photocopy is as valid as the original. I understand that I may revoke this authorization at any time by notifying Horizon NJ Health in writing at the address provided below. I understand that a revocation will not apply to information that was already disclosed. I understand that once information has been disclosed according to these instructions, the Health Insurance Portability and Accountability Act (HIPAA) and other privacy laws may no longer protect the information.

Signature of ☐Member ☐Legal Representative:_____Date:___/___/_____

(check whether member or legal representative)

Printed Name: _____

INSTRUCTIONS

REQUEST FOR APPOINTMENT OF LIMITED REPRESENTATIVE

(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 your personal health information to be disclosed to another person. This person will not be permitted to make changes to your policy or other information. This form cannot be used to assign a person as your legal representative with the right to act on your behalf. If you wish to assign a legal representative please complete the Documentation of Legal Representative Status for Member form.

Member's Information Section:

This section requests information related to the member for which a limited 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.

Limited Representative Information Section:

The requested information in this section will be used by Horizon NJ Health for identification and verification purposes. The limited 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 termination date is entered, the request will remain in effect until the member or legal representative notifies the change to Horizon NJ Health in writing.

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: (609)538-1574

HNJH_HIPAA_Team@horizonblue.com