KelseyCare Advantage

AUTHORIZATION TO COMMUNICATE

PURPOSE: You give permission to KelseyCare Advantage to share your personal health information with an authorized person. To do so, please complete and sign this form. This form allows KelseyCare Advantage to communicate plan coverage information, premium amounts and how you pay, referral information, billing, referrals, claims, pharmacy, and eligibility inquiries with the individual listed below.

The person cannot change your plan, make a request for service, appeal or file a grievance for you. The person cannot change your physical address, or your phone number. You, your Power of Attorney, guardian or conservator must give us the change.

KelseyCare Advantage Member Information: (this section must be completed)

Member Name			**Medicare or Insurance ID #**		
Address					
City			**St**		**Zip**
Phone Number		**Birth date**		**Email**	

Who Do You Want to Share Your Information With? (this section must be completed)

Representative Name		**Relationship to Member/ Beneficiary**			
Address (optional)					
City		**St**		**Zip**	
Phone Number					

Your Permission: (this section must be completed)

I have read and understand this information. I may revoke or change this authorization at any time in writing to KelseyCare Advantage; and the revocation shall be effective except to the extent that KelseyCare Advantage has already used or disclosed information in relation to this Authorization. The Health Insurance Portability and Accountability Act (HIPAA) protects your health information. But we can't control what happens to your information after we share it with the person or organization you name on this form. At that point, HIPAA or federal privacy laws may not protect your information. It could be shared with others.

By signing this form, I acknowledge that I have read and understand this information. I have a right to receive a copy of this form.

Signature: _____

KelseyCare Advantage Member

Date: _____

Signature: _____

Authorized Representative

I hereby accept the above appointment.

Date: _____

Duration:

In most cases, permission to share personal health information ends on your last day as a plan member or you write to us and let us know to end it. The effective date is valid from the date signed, unless revoked.

Please mail, email, or fax this form to:

Mail:
KelseyCare Advantage
P.O. Box 841569
Pearland, Texas 77584

Email: memberservices@kelseycareadvantage.com

Fax: (713) 442-5450