Essential StaffCARE Authorized Representative Form

BCS | PAI Planned Administrators Incorporated

Reason for this form: This is to be used so that Protected Health Information on a claimant is not released to anyone other than those specifically authorized by the claimant.

Section 1. Appointment of Authorized Representative

I appoint: Name: ______________________ Telephone: (____) ____—______

Address: ______________________
Street City State ZIP

as my authorized representative for the purposes described in Sections 2 and 3 below. I understand this agreement is voluntary and made to confirm my direction.

I understand that my authorized representative may further disclose my information, and it may not be protected by federal or state privacy laws.

Name: ______________________ Telephone: (____) ____—______

Address: ______________________
Street City State ZIP

E-mail: ______________ Identification Number: ______________ Group Number: ______________

Section 2. Scope of Authority

I authorize the disclosure of my protected health information to my authorized representative for the following purposes (check only one):

- ☐ Disclose my claim for claim # ______________ only.
- ☐ Disclose all claims related to my diagnosis of ______________ only.
- ☐ Disclose all claims for ______________ provider only (write name of physician or hospital).
- ☐ Disclose all claims for ______________ date(s) of service (write specific date or span of dates).
- ☐ Disclose all of my claims regardless of dates of service, provider or diagnosis.
- ☐ Other: ______________________

Section 3. Options for Disclosures

I authorize the disclosure of my protected health information to my authorized representative by the following means (check only one):

- ☐ Disclose my protected health information by telephone only.
- ☐ Disclose my protected health information by sending all original documents by U.S. mail only. (*I understand that choosing this option means that all further disclosures will be given to my authorized representative for all members listed on this policy.)
- ☐ Disclose my protected health information by both telephone and U.S. Mail. (*I understand that choosing this option means that all further disclosures will be given to my authorized representative for all members listed on this policy.)

Section 4. Expiration and Revocation

Expiration: This authorized representative appointment will expire (check only one):

- ☐ On ____/____/____
- ☐ On the occurrence of the following event: ______________________
- ☐ Upon my revocation

Revocation: I understand that I may revoke this authorization at any time by giving written notice of my revocation to:
Planned Administrators, Inc., P.O. Box 6702, Columbia, SC 29260-6702 Telephone: (866) 798-0803

I understand that revocation of this appointment will not affect any action you took in reliance on this appointment before you received my notice of revocation.

Section 5. Signature

I, ______________________, have had full opportunity to read and consider the contents of this appointment, and I confirm that the contents are consistent with my direction. I understand that, by signing this form, I am confirming my appointment of my authorized representative, the scope of my authorized representative's authority, the means by which my authorized representative shall receive disclosures, the expiration of this appointment and the option of revoking of this appointment.

Signature: ______________________ Date: ______________

Please return the completed form to: Essential StaffCARE, P.O. Box 6702, Columbia, SC 29260-6702

Thank you for your cooperation.
Claims Representative

Form # 8.717 ESC

Rvs. 03/08