FARM BUREAU HEALTH PLAN

PERSONAL REPRESENTATIVE APPOINTMENT AND AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (For Farm Bureau Health Plan)

This form is used to authorize Farm Bureau Health Benefit Plan, LLC ("Farm Bureau Health Plan") and its administrator, Wellmark Administrators, Inc., to disclose protected health information at the request of the individual.

INDIVIDUAL AUTHORIZING DISCLOSURE

Name: _____

Address: _____

City, State, Zip Code: _____

Telephone: _____ E-mail: _____

Identification Number: _____ Social Security Number: _____

PERSONAL REPRESENTATIVE APPOINTMENT

I appoint the individual named below to act on my behalf as my Authorized Personal Representative with Farm Bureau Health Plan and its administrator, Wellmark Administrators, Inc., in connection with:

☐ All my claims or inquiries for health care benefits on and after the effective date of this appointment.

☐ My inquiries and claims for health care benefits with the dates of service: [specify dates]

_____

☐ All inquiries and claims for health care benefits for the following minor dependent(s): [specify names]

_____

☐ My appeal of a benefit determination denied on: [specify date of denial letter] ____/____/____ or denied claim(s) with the date(s) of service: [specify dates] _____

☐ My appeal of a coverage denial or rescission decision.

PERSONAL REPRESENTATIVE

Name: _____

Address: _____

City, State, Zip Code: _____

Telephone: _____ E-mail: _____

Effective: This appointment of Authorized Personal Representative and authorization to disclose is effective upon receipt by Wellmark Administrators, Inc. of a fully completed and signed original or exact copy of this form at the address stated below.

Expiration: This appointment and authorization will expire 30 days after termination of my health plan coverage, or upon settlement of claims incurred while covered, unless revoked or an earlier date or event is entered below.

☐ On ____/____/____ (Date)

☐ On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized):

_____

_____

Right to Revoke: I understand that I may revoke this appointment and authorization at any time by giving written notice of my revocation to Farm Bureau Health Plan and its administrator, Wellmark Administrators, Inc., at the address stated below. I understand that revocation of this appointment and authorization will not affect any action you took in reliance on this appointment and authorization before you received my written notice of revocation.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Protected Health Information to be Disclosed: I authorize Farm Bureau Health Plan and its administrator, Wellmark Administrators, Inc., to disclose the protected health information described in this form to the named Authorized Personal Representative.

This authorization shall include and apply to any and all protected health information related to treatments where the individual has requested a restriction and/or for any health care item or service for which the health care provider has been paid out of pocket in full.

Effect of Granting this Authorization: I understand that if the person or entity that receives the information requested is not covered by federal or state privacy laws, the information described above may be redisclosed and will no longer be protected by law.

Prohibition on Redisclosure: This form does not authorize the disclosure of medical information beyond the limits of the authorization. Where information has been disclosed from the records protected by Federal law for alcohol/drug abuse records or state law for mental health records, the Federal requirements (42 CFR Part 2) and state requirements (Iowa Code Chapter 228) prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

No Conditions: This authorization is voluntary. Farm Bureau Health Plan and its administrator, Wellmark Administrators, Inc., will not condition your enrollment in a health plan, eligibility for benefits or payment of claims on giving this authorization.

Specific Authorization for Mental Health, Substance Abuse Treatment or AIDS-Related Information:

I authorize and consent to the release and disclosure of any and all protected health information, as described in this form, including specifically mental health information, substance abuse (drug or alcohol), and AIDS-related information, if applicable, to the individual named as long as this appointment of Authorized Representative is in effect. I understand that I may inspect the mental health information disclosed.

I have had full opportunity to read and consider the contents of this personal representative appointment and authorization, and I understand that, by signing this form, I am confirming authorization of the disclosure of my protected health information, as described in this form. If this authorization involves the disclosure of mental health information, I acknowledge receipt of a copy of the authorization.

Individual's Signature (or Legal Guardian if applicable): _____ **Date**: / /

Print Name of Legal Guardian if applicable*: _____

**If a legal guardian signs for an individual, a copy of the guardian appointment document must be submitted with this form.*

RETAIN A COPY FOR YOUR RECORDS

Send completed and signed form to:

Wellmark Administrators, Inc.
Privacy Office, Mail Station 5W590
PO Box 9232
Des Moines, IA 50306-9232
Or fax to (515)376-9032