

Equivalent Notice for Release of Medical Information

Plan Member Name/Beneficiary Identification

Name (Last, First, MI):		Medicare or Insurance ID Number:	
Street Address:			
City:		State:	Zip:
Birth date:	Phone number:	Email:	

Information I authorize to be released to the below individual: *(Check all that apply)*

<u>1a. Medical Benefits (Part B)</u>	<u>1b. Pharmacy Benefits (Part D)</u> <i>Complete this section if you have Pharmacy Benefits with KelseyCare Advantage</i>
<input type="checkbox"/> All Information	<input type="checkbox"/> All Information
<input type="checkbox"/> Billing Issues / Claims	<input type="checkbox"/> Billing Issues / Claims
<input type="checkbox"/> Referrals / Appeals	<input type="checkbox"/> Referrals / Appeals
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

1. NAME PERSON REPRESENTING THE BENEFICIARY:

I appoint the below individual to act as my representative.

Name of Representative (Last, First, MI):		Relationship to the Beneficiary	
Street Address:			City:
State:	Zip:	Phone Number:	

2. DURATION (Check one)

This authorization shall become effective from (start date) _____ To _____ (end date)

This authorization shall become effective (start date) _____ and shall remain in effect for the remainder of this plan year.

3. ACCEPTANCE OF REPRESENTATIVE (To be completed by the Party that will be Representing the Member)

I, _____, hereby accept the above appointment.

Signature of Representative

Date

4. 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 have already used or disclosed information in reliance to this Authorization.

By signing this form, I acknowledge that I have read and understand this information.

I have a right to receive a copy of this authorization.

Signature of Plan Member

Date

Please Email, Fax or Mail Form To:

KelseyCare Advantage

P.O. Box 841569

Pearland, Texas 77584

Fax: (713) 442-5450

Email: memberservices@kelseycareadvantage.com