EQUIVALENT NOTICE FORM

Complete, sign where indicated and return this form if you would like to give another person authorization to speak to a KelseyCare Advantage representative on your behalf.

Once completed and returned, the person you appoint to represent you will be able to discuss Medical and Pharmacy Benefits on your behalf. You can return the signed form to us either by email, fax or mail:

Email: memberservices@kelseycareadvantage.com

Fax: (713) 442-5450

Mail:

KelseyCare Advantage
PO Box 841569
Pearland, TX 77584

EQUIVALENT NOTICE FOR RELEASE OF MEDICAL INFORMATION

Purpose: I authorize information to be released to the individual listed below including *billing, referrals, claims, and appeals*.

KelseyCare Advantage Member Information

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

☐ **Medical Benefits** Information

☐ **Pharmacy Benefits** Information

Please check one or both options

Authorized Representative Information

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

Consent

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.

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.

over

_____ _____

KelseyCare Avantage Member Signature

Authorized Representative Signature
I hereby accept the above appointment.

_____ _____

Date

Date

Duration

This authorization shall be effective for one year. The effective date is valid from the date signed, unless revoked.

Please mail, email or fax the form to:

KelseyCare Advantage
P.O. Box 841569
Pearland, Texas 77584
Fax: (713) 442-5450
Email: memberservices@kelseycareadvantage.com