APPROPRIATE USE CASES FOR DESIGNATING INDIVIDUALS ACCESS TO YOUR PERSONAL HEALTH INFORMATION

AND WHICH FORMS TO SUBMIT.

At Mass Advantage, we understand that navigating the processes for sharing personal health information can sometimes be complex. Forms like the **Authorization for Release of Protected Health Information (PHI)** and the **Appointment of Representative (AOR)** exist to serve distinct purposes in ensuring that your health information is shared securely and in compliance with privacy regulations. Below is a breakdown of use cases and which form should be used. **If you are submitting a PHI form, we highly recommend you also submit the AOR form so that if in the future you need to submit an appeal or determination, it is already on file.**

Use Cases	Form(s) to Submit
• Authorize Mass Advantage **to disclose member's protected health information** • Named individual can help the member with plan information like claims, benefits, and coverage information • **DOES NOT** give the named individual/ organization the authority to make changes or decisions on behalf the member	Authorization for Release of Protected Health Information (PHI)
• Member wants to authorize an **individual to act on their** behalf in filing a grievance, requesting a coverage determination, or requesting an appeal • **DOES NOT** give the named individual the authority to make changes or decisions on behalf of the member beyond the scope of their appointment	Appointment of Representative (AOR)
• Member wants to allow someone to **make all decisions on their behalf** beyond the scope of an AOR • Personal Representative stands in the shoes of the individual and has the **legal authority** to act for the individual and exercise the individual's rights	Examples include, but are not limited to, health care Power of Attorney, heath care Proxy, conservatorship, other court orders. Seek legal counsel to confirm which forms apply to your circumstance and then provide them to Mass Advantage.

On the following pages are copies of the **Authorization for Release of Protected Health Information (PHI)** and the **Appointment of Representative (AOR)** forms for your review and submission, as necessary.

Forms can be submitted to Mass Advantage by mail or fax:

By Mail:

Mass Advantage
P.O. Box 219975
Kansas City, MO 64121-9975

By Fax: (816) 502-4585

Should you wish to remove a previously named individual in either the PHI or AOR form, please call Member Services or write to the address or fax above and notify us. Your provided information will cancel the authorization, and we'll no longer be able to share your personal health information with the named individual.

If you have any questions on which form to fill out based on your circumstances, please call Member Services at (844) 918-0114 (HMO) or (844)-915-0234 (PPO) (TTY: 711). Calls to these numbers are free. From October 1 to March 31, we're available 7 days a week from 8 am to 8 pm EST. From April 1 to September 30, we're available Monday through Friday from 8 am to 8 pm EST.

Authorization for Release Protected Health Information (PHI) Form

MASS ADVANTAGE

I understand that completing this form authorizes Mass Advantage and its subsidiaries, affiliates, employees, agents and subcontractors, to share my private health record, known as Protected Health Information (PHI), with the individual or organization named in this form.

For help in completing this form, please call Member Services at (844) 918-0114 (HMO) or (844) 915-0234 (PPO), TTY: 711. October 1 – March 31, 8 am – 8 pm EST, 7 days a week and April 1 – September 30, 8 am – 8 pm EST, Monday – Friday.

1. My Information:

First Name _____ Last Name _____ Middle Initial _____

Mass Advantage ID# _____ Date of Birth *(mm/dd/yyyy)* _____ Phone Number _____

Street _____ City, State, Zip _____

2. Mass Advantage is authorized to share my PHI with the following individual or organization:

Person or Organization Name _____

Phone Number _____ Date of Birth (if person) _____

Street _____ City, State, Zip _____

Person's Relationship to You. Please be specific (e.g. son, daughter, spouse, parent, etc). _____

3. Mass Advantage can share ONLY my records chosen below.

You must check the box next to the information you want shared. This authorization cannot be used to share psychotherapy notes.

[ ] **All my information:** I would like Mass Advantage to share **all my information** requested by the person or organization named in Section 2. This may include a diagnosis (name of illness or condition), procedure (type of treatment), claims, doctors and other health care providers, and financial information (like premium and billing). This does not include psychotherapy notes.

-OR-

[ ] If "all my information" is not checked above, I would like to **limit the disclosure** of information. I authorize Mass Advantage to disclose **only the following specific information** to the person or organization named in Section 2. Make your selection(s), below.

[ ] Health (medical, dental, pharmacy, vision and prepaid benefit card information)

[ ] Long Term Care [ ] Patient Management Records

[ ] Substance Use Disorder (alcohol/drug) [ ] HIV/AIDS

[ ] Sexually Transmitted Diseases

[ ] Behavioral Health/Mental Health (but NOT Psychotherapy notes)

[ ] Other Sensitive Services (such as gender affirming care or sexual or reproductive health

[ ] Other (please be specific): _____

_____

4. By signing this form I authorize Mass Advantage to disclose information below for the following purpose.

Check one of the following options:

[ ] At My Request - no specific purpose [ ] Specific Purpose: _____

5. This form will be valid for one year from the date of your signature, unless a shorter time period is listed below.

My authorization is valid from

_____ _____

(mm/dd/yyyy) *(mm/dd/yyyy)*

6. By signing below, I understand and agree:

- The information I agree to share may be sensitive and may include detailed information on treatments, diagnoses, chronic diseases, behavioral/mental health conditions, alcohol or drug abuse, communicable diseases, sexually transmitted diseases such as HIV/AIDS, and genetic marker information."
- If the person or entity I authorize to receive the information described above is not subject to federal health information privacy laws, they may further release the protected health information and it may no longer be protected by federal privacy laws.
- Mass Advantage cannot condition my treatment, payment, enrollment, or my eligibility for benefits and payment for services if I do not sign this form. However, without a valid form, my request to release information to the individual or organization named above cannot be fulfilled.
- I may revoke this authorization at any time by submitting a request in writing to Mass Advantage's Compliance/Privacy Office either by mail to Mass Advantage, ATTN: Compliance Department, P.O. Box 219975, Kansas City, MO 64121-9975 or by fax at (816) 502-4585.
- Revoking this authorization will not affect any action Mass Advantage took prior to receipt of the request.

7. My signature or my legal representative's signature

_____ _____

Signature Date

_____

Printed Name of Member

If a legal representative signed this form, describe the relationship (parent, legal guardian, Power of Attorney, personal representative).

_____

- If you are signing this form on behalf of the member, you **must provide the supporting documentation authorizing you** to represent the member (e.g. Power of Attorney, Healthcare Proxy)
- If you are making this request on behalf of a minor child, we may require additional information before this request is considered complete.

Please sign and return this completed form to:

Mass Advantage
P.O. Box 219975
Kansas City, MO 64121-9975
or fax to: 816-502-4585

Form Approved
OMB No. 0938-0950
Expires: 08/31/2025

Appointment of Representative

Use this form to appoint a representative to act on your behalf for your claim, appeal, grievance or request. By signing this form and appointing this representative, you agree that the representative will be the main contact and have authority to make requests, present evidence, get information, and receive all communication about your action. This person may see your personal medical information. **All fields in Sections 1 and 2 are required unless marked optional.**

Section 1: Information about the person appointing the representative

This section must be completed by the patient, provider or other person appointing a representative.

Name	Medicare Number or National Provider Identifier
Mailing address	Phone number (with area code) ( ) -
City	State / ZIP code
Email (optional)	Fax (optional) ( ) -
Signature	Date signed (mm/dd/yyyy) / /

Section 2: Information about the representative

This section must be completed by the representative.

Representative name

Professional status or relationship to the person in Section 1 (attorney, relative, etc.)

Mailing address	Phone number (with area code) ( ) -
City	State / ZIP code
Email (optional)	Fax (optional) ( ) -

By signing below, you agree to act as a representative and certify that you haven't been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS) or otherwise disqualified from acting as a representative. Any fee to be charged for acting as a representative may be subject to review and approval by the Secretary. If you're charging a fee, go to instructions on page 2.

Signature	Date signed (mm/dd/yyyy) / /

Representative must complete the sections below, if applicable (go to instructions on page 2)

Section 3: Waiver of fee for representation

Providers and suppliers who furnished the items or services at issue can't charge a fee for representation and must sign below to waive their fee. Representatives who choose to waive their fee for representation must also sign below.

I waive my right to charge and collect a fee for representing the person in Section 1 before the Secretary of HHS.

Signature	Date signed (mm/dd/yyyy) / /

Section 4: Waiver of payment for items or services at issue

If you're a provider or supplier and you furnished items or services to the patient you're representing, if the appeal involves a question of whether you or the patient didn't know, or couldn't reasonably be expected to know, that Medicare wouldn't cover the items or services.

I waive my right to collect payment from the patient for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is made.

Signature	Date signed (mm/dd/yyyy) / /

Instructions and Regulation Requirements

Instructions

All fields in Sections 1 and 2 are required unless marked "optional." If the person or entity appointing a representative doesn't have a Medicare number or National Provider Identifier, fill in "not applicable." Go to the regulation at 42 CFR 405.910: ECFR.gov/current/title-42/chapter-IV/subchapter-B/part-405/subpart-I/section-405.910

Waiver of Fee for Representation Section 3 is required when a representative is required, or has agreed, to waive or not charge a fee for their representation. Waiver of Payment for Items or Services at Issue Section 4 is required if a provider or supplier who furnished items or services to the patient represents the patient and liability (knowledge of non-coverage) under §1879(a)(2) of the Act is at issue in the appeal. Go to 42 CFR 405.910(f).

An appointment of a representative is considered valid for one year from the date this form is signed by both the person appointing a representative and the appointed representative. A completed form can be used for other appeals or actions during the one-year period it's valid. Unless revoked, the representation is valid for the duration of the claim, appeal, grievance, or request for which it was filed.

Charging fees for representing patients before the Secretary of HHS

An attorney, or other representative for a patient, who wants to charge a fee for services rendered in connection with an appeal before the Secretary of HHS (i.e., an Administrative Law Judge (ALJ) hearing or attorney adjudicator review by the Office of Medicare Hearings and Appeals (OMHA), Medicare Appeals Council review, or a proceeding before OMHA or the Medicare Appeals Council as a result of a remand from federal district court), is required to have the fee approved in accordance with 42 CFR 405.910(f).

The representative should complete the form OMHA-118, "Petition to Obtain Approval of a Fee for Representing a Beneficiary" and file it with the request for ALJ hearing, OMHA review, or request for Medicare Appeals Council review. Fee approval is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court-appointed representative, and the court approved the fee; (3) the fee is for representing a patient in a proceeding in federal district court; or (4) the fee is for representing a patient in a redetermination or reconsideration. Representatives are permitted to waive their fee if they choose. Get form OMHA-118 here: HHS.gov/sites/default/files/OMHA-118.pdf

A provider or supplier who furnished the items or services to a Medicare patient that are the subject of the appeal may represent that patient in an appeal, but the provider or supplier may not charge the beneficiary any fee associated with the representation. (42 CFR 405.910(f)(3).)

Approval of fee

The fee approval requirement ensures that a representative is paid fairly for their services and that patient fees are reasonable. In approving a requested fee, OMHA or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required, the amount of time spent on the case, the results achieved, the level of administrative review needed, and the amount of the fee requested.

Conflict of interest

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain current and former officers and employees of the United States to render certain services in matters affecting the government or to aid or assist in prosecuting claims against the United States. Individuals with a conflict of interest are excluded from serving as representatives of patients before HHS.

Where to send this form

Send this form to the same location you send your claim, appeal, grievance, or request.

Get help & more information

For questions about this form, contact your Medicare plan or call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

You have the right to get Medicare information in an accessible format, like large print, braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice, or call 1-800-MEDICARE for more information.