Designation of Personal Representative

CareFirst Medicare Advantage

You may designate a personal representative who will act on your behalf in making decisions related to health care, which includes treatment and payment issues. This individual can be a family member, friend, lawyer, or unrelated party.

Please type or print neatly. We will not process incomplete or illegible forms. Please keep a copy of this document for your records.

Please mail or fax this authorization to: CareFirst BlueCross BlueShield, Privacy Office, PO Box 14858, Lexington, KY 40512 Fax: 410-505-6692

DESIGNATION OF PERSONAL REPRESENTATIVE IS GIVEN TO			
Name of Health Insurance Plan **CareFirst BlueCross BlueShield Medicare Advantage**			
TO RELEASE RECORDS OF			
Last Name, First Name, MI			Member / Plan ID
Street Address			
City		State	ZIP
Home Phone	Work Phone	Date of Birth (mm/dd/yyyy)	
I HEREBY DESIGNATE THE FOLLOWING INDIVIDUAL(S) AS MY PERSONAL REPRESENTATIVE(S)			
Name of Individual		Phone	
Street Address			
City		State	ZIP
Signature of Appointee			
Relationship to Member		Appointee Signature Date	
I hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.			

I HEREBY DESIGNATE THE FOLLOWING INDIVIDUAL(S) AS MY PERSONAL REPRESENTATIVE(S)		
Name of Individual	Phone	
Street Address		
City	State	ZIP
Signature of Appointee		
Relationship to Member	Appointee Signature Date	
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Name of Individual	Phone	
Street Address		
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Signature of Appointee		
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PLEASE READ EACH OF THE FOLLOWING STATEMENTS CAREFULLY BEFORE SIGNING THIS DOCUMENT	
1. I understand that this designation will expire one year from my signature date. 2. I understand that this designation is voluntary and being made at my request. 3. I understand that the released information may no longer be protected by federal privacy laws and may be redisclosed by the individual or organization that receives the information. 4. I understand that I may refuse to sign this designation form. My health care provider will not condition treatment and my health plan will not condition payment, enrollment, or eligibility on my signing this designation. 5. I understand that I may revoke this designation of personal representative at any time by sending a written notification to the Privacy Office at the address listed on page 1, and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective for information that my health plan has already used or disclosed, relying on this designation.	
Signature	Date
Must be the original signature of any person 18 years of age or older whose records have been requested. If this request is made by a personal representative on behalf of the individual, please attach a complete copy of the personal representative form or legal document indicating your legal authority to sign this form.	

Any mental health or substance use disorder information, which has been disclosed from medical or other health care records, may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) and/or Washington, D.C. and Maryland mental health laws prohibit the recipient of the information from making any further disclosure of this information unless such disclosure is expressly permitted by the written consent of the person to who it pertains, or as otherwise permitted by 42 CFR Part 2 and/or Washington, D.C. and Maryland mental health laws. 42 CFR Part 2 prohibits unauthorized disclosure of these records.

Notice of Nondiscrimination and Multi-Language Insert

(UPDATED 8/5/19)

CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc., CareFirst Diversified Benefits and all of their corporate affiliates (CareFirst) comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. CareFirst does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

CareFirst:

- Provides free aid and services to people with disabilities to communicate effectively with us,
  - such as: Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English,
  - such as: Qualified interpreters
  - Information written in other languages

If you need these services, please call 1-833-320-2664.

If you believe CareFirst has failed to provide these services, or discriminated in another way, on the basis of race, color, national origin, age, disability or sex, you can file a grievance with our CareFirst Civil Rights Coordinator by mail, fax or email. If you need help filing a grievance, our CareFirst Civil Rights Coordinator is available to help you.

To file a grievance regarding a violation of federal civil rights, please contact the Civil Rights Coordinator as indicated below. Please do not send payments, claims issues, or other documentation to this office.

Civil Rights Coordinator, Corporate Office of Civil Rights

Mailing Address	P.O. Box 8894 Baltimore, Maryland 21224
Email Address	**civilrightscoordinator@carefirst.com**
Telephone Number	410-528-7820
Fax Number	410-505-2011

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-833-320-2664. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-833-320-2664. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-833-320-2664。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-833-320-2664。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-833-320-2664. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-833-320-2664. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chýõng sức khỏe và chýõng trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-833-320-2664 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-833-320-2664. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-833-320-2664 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-833-320-2664. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية لإلجابة عن أي أسئلة تتعلق بالصحة أو جدول أألدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى االتصال بنا على 1-833-320-2664. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके ककसी भी प्रश्न के जवाब देने के िए हमारे पास मुफ्त दुभाकिया सेवाएँ उपिब्ध हैं. एक दुभाकिया प्राप्त करने के किए, बस हमें 1-833-320-2664 पर फोन करें. कोई व्यक्ति जो िहन्दी बोिता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-833-320-2664. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-833-320-2664. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-833-320-2664. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-833-320-2664. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-833-320-2664 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。