Personal Representative Request Form

Please print clearly in blue or black ink.

FirstChoice℠ by Select Health of South Carolina

Your Hometown Health Plan

Healthy Connections

This form will need to be completely filled out for it to be processed. This includes attaching legal documentation (see page 2).

This form allows another person to make health care decisions for a First Choice by Select Health of South Carolina member. This person must have legal authority to act on your behalf. This includes legal guardianship or health care power of attorney. If you have questions, you can call Member Services at **1-888-276-2020** or send a fax to **1-843-569-4807.**

Member information

First name:	Middle initial:	Last name:
Member ID number:		Date of birth (MM/DD/YYYY): ☐☐/☐☐/☐☐☐☐
Address line 1:		
Address line 2:		
City:	State: ☐☐	ZIP code: ☐☐☐☐☐
Home phone number (including area code): (☐☐☐) ☐☐☐ - ☐☐☐☐		
Mobile phone number (including area code): (☐☐☐) ☐☐☐ - ☐☐☐☐		
Email address:		

Personal representative information

First name:	Middle initial:	Last name:
Address line 1:		
Address line 2:		
City:	State: ☐☐	ZIP code: ☐☐☐☐☐
Home phone number (including area code): (☐☐☐) ☐☐☐ - ☐☐☐☐		
Mobile phone number (including area code): (☐☐☐) ☐☐☐ - ☐☐☐☐		
Email address:		
Relationship to member:		Date of birth (MM/DD/YYYY): ☐☐/☐☐/☐☐☐☐

Please keep a copy of this form for your records.

A copy of legal documentation must be attached to this form. If you do not attach legal documentation, this form cannot be processed.	
Type of documentation you are attaching:	
☐ Power of attorney for health care decisions ☐ Legal guardianship ☐ Custodial order ☐ Executor of estate	☐ Other (please specify):

Signature and date of member's legal personal representative
Name (print):
Personal representative's signature:
Date (MM/DD/YYYY): ☐☐/☐☐/☐☐☐☐

Important information about personal representatives

The federal Privacy Rule requires Select Health of South Carolina to follow certain procedures before it may provide access to your protected health information (PHI) to someone other than you. PHI is information about you that can reasonably be used to identify you and that relates to your past, present, or future physical or mental health or condition and the provision of health care to you or the payments for that care. Select Health of South Carolina will release PHI to your personal representative upon receipt of documentation supporting their legal authority to make health-related decisions on your behalf (for example, a valid power of attorney, guardianship, or other legal document). Select Health of South Carolina will also recognize as a personal representative an executor, an administrator, or a person recognized by law as having authority to act on behalf of a deceased member or the member's estate.

This is what you need to know:
Information about your health is very personal. We are committed to protecting your privacy. Please read this form carefully. This form will need to be completely filled out for it to be processed. This includes attaching legal documentation.

Select Health of South Carolina will not, however, treat someone as your personal representative if we reasonably believe: (1) you may be subject to domestic violence, abuse, or neglect by the personal representative; (2) treating the person as your personal representative could endanger you; or (3) in the exercise of professional judgment (for example, in a licensed professional's judgment), Select Health of South Carolina decides that it is not in your best interest to treat the person as your personal representative.

Please keep a copy of this form for your records.

This is what you need to know:
We care about your well-being. If we think your personal representative will misuse your health information, we will not give it to them.

A personal representative designation will remain in effect until the member, a court order, or an applicable law revokes it.

This is what you need to know:
If you allow for a personal representative, this document will remain effective until it is canceled. You can cancel this if you want to. You just have to tell us. A court order or other laws can also cancel it.

To assist Select Health of South Carolina in responding to this request, please complete this form by printing or typing into the spaces provided. Attach additional pages if necessary to clarify your request. Attach a copy of the document supporting your personal representative's legal authority to act on your behalf.

This is what you need to know:
This form will need to be completely filled out for it to be processed. This includes attaching legal documentation. You may use additional pieces of paper if you need more space to write.

Mail the completed form and supporting documentation to:

Select Health of South Carolina
Consent Processing Center
P.O. Box 7092
London, KY 40742-7092

Questions? Call Member Services at

1-888-276-2020 (fax 1-843-569-4807).

If your primary language is not English, language services are available to you, free of charge. Call **1-888-276-2020** (**TTY 1-888-765-9586**).

Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-888-276-2020** (**TTY 1-888-765-9586**).

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www.selecthealthofsc.com