Print Name of Member _____ **ID #**_____

Member E-mail Address _____

National Elevator Industry Health Benefit Plan
19 Campus Blvd., Suite 200
Newtown Square, PA 19073
1-800-523-4702

AUTHORIZATION FORM
(For Use or Disclosure of Protected Health Information)

PURPOSE OF THIS FORM

In order for the NEI Health Benefit Plan ("Benefits Office") to use or disclose Protected Health Information to someone other than you, you must complete this Authorization Form and return it to the Benefits Office.

Protected Health Information ("PHI") is information that is created, received, transmitted or stored by the Benefits Office which relates to your past, present, or future physical or mental health, health care, or payment for health care, and either identifies you or provides a reasonable basis for identifying you. Except as permitted by law, the Benefits Office may not use or disclose PHI to persons other than those you specify on this form.

The Benefits Office may request that you complete this form where the use or disclosure of information is necessary to carry out its functions. In addition, you may submit this form to the Benefits Office because you want someone to request or receive your PHI from it. This form is not used if you are requesting your own PHI.

_____
Print Name of Individual/Patient (if authorizing below)

ALL OF THE FOLLOWING PARTS MUST BE COMPLETED

PART I: Authorized Person(s)

I authorize the Benefits Office to disclose the PHI identified in Part II of this form to the following person(s): *(Please designate person[s] and fill in their name and address)*

☐ Spouse _____

☐ Any representative of my local union #____ ☐ Specific representative only _____

☐ Attorney_____

☐ Other Person(s) _____

PART II: Description of the information to be used or disclosed

I authorize the Benefits Office to disclose PHI (including written, electronic, or oral information) to the person(s) identified in PART I of this form in connection with **(mark all that apply)**: (If you want different people to have access to different information, you must fill out separate forms.)

☐ All Claims and Eligibility Information ***(this option will provide uninterrupted service to the authorized individual)***

☐ All Claims Information only

☐ All Eligibility Information only

☐ Specific Medical, Dental, Vision, or Other Claim for Health Benefits
Provider: _____
Date(s) of Service: _____

☐ Other (please be as specific as possible) _____

PART III: Purpose of use or disclosure

The purpose(s) for which the individual(s) named in Part I of this Authorization Form may have access to my PHI is as follows: **(mark all that apply)**:

☐ Health care claims or appeals

☐ Payment for health care

☐ Coordination of benefits

☐ Health care claim status

☐ Coverage

☐ Eligibility for benefits

☐ Premiums and co-payments

☐ Preauthorization

☐ Subrogation and reimbursement

☐ Disease Management

☐ **(All of the above)**

☐ Other event (please state what the event is): _____

☐ I am requesting disclosure of PHI for personal reasons.

PART IV: Validity of Form (check one only)

This Authorization Form is valid for the period checked below; otherwise, it will terminate in one year or when I cancel the authorization by completing a Cancellation of Authorization Form.

☐ As long as I am covered by the Plan

☐ More than a year ending on ___/___/_____

☐ Until the issue raised in Part II is resolved

☐ _____

Specify other event or time

PART V: Acknowledgment and Signature

I understand that:

- **I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION FORM.**
- **I HAVE THE RIGHT TO REVOKE THIS FORM AT ANY TIME BY SUBMITTING A CANCELLATION OF AUTHORIZATION FORM TO THE BENEFITS OFFICE.**
- **CANCELLATION WILL TAKE EFFECT AS OF THE CANCELLATION DATE OR EVENT, OR ONCE THE BENEFITS OFFICE RECEIVES THE CANCELLATION OF AUTHORIZATION FORM.**
- **THE PERSON(S) I AM AUTHORIZING TO RECEIVE MY PHI MAY NOT BE REQUIRED TO TREAT THIS INFORMATION AS CONFIDENTIAL OR PROTECTED HEALTH INFORMATION.**

_____ _____

Your Signature (or Signature of Personal Representative*) Date

*If you are acting as the Personal Representative of the individual whose PHI is to be disclosed, you must provide proof of your authority to act for that individual.