MID AMERICA
EMPLOYEE BENEFIT ADMINISTRATION

DESIGNATED REPRESENTATIVE FORM

Issued: _____ Effective: _____

Revised: _____ Approved By: _____

EXPIRES: Upon Employee notification of termination

Mid-America Associates requires an authorization for the disclosure of Protected Health Information (PHI) beyond the restriction established by the HIPAA Privacy standard 45 CFR Parts 160 through 164. Mid-America Associates is the Third-Party Administrator (hereinafter referred to as "Administrator") for the Plan. The Administrator has a valid Business Associate Agreement with the Plan who is the Covered Entity.

The Plan (Covered Entity): _____

General Requirements:

1. Administrator will disclose protected health information without an authorization to the individual receiving care for those activities that are required to carry out treatment. The disclosure of any PHI beyond this limitation will require an authorization.
2. An authorization by the individual receiving care or their personal representative will be the standards.
3. An authorization must contain at least the following elements:
   a. A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.
   b. The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure.
   c. An expiration date or an expiration event.
   d. A statement of the individual's right to revoke the Authorization in writing.
   e. A statement that the Administrator does not condition payment, eligibility or enrollment of health care services on the individual signing of the authorization.

   A signature of the individual and date when Administrator obtained or received a valid authorization for its use or disclosure of protected health information.

SIGNATURE OF MEMBER AUTHORIZING RELEASE OF PERSONAL HEALTH INFORMATION TO THE ASSIGNED DESIGNATED REPRESENTATIVE:

_____ _____
NAME OF PATIENT - Please Print Relationship

_____ _____
NAME OF PATIENT - Please Print Relationship

_____ _____
NAME OF PATIENT - Please Print Relationship

_____ _____
SIGNATURE OF PATIENT (if Spouse or Dependent Child Age 18 years of Older) Date

_____ _____
SIGNATURE OF EMPLOYEE (if Patient is a Minor) Date

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MID AMERICA
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Page Two

Designated Representative Form

I, (Employee Name)_____authorize the release of Confidential Patient Medical Information to the following Designated Representative:

AUTHORIZED DESIGNATED REPRESENTATIVE:

_____ _____
Please Print Full Name Date

[OPTIONAL]

I Authorize the Designated Representative to receive all mail at the address listed below for the Patients listed:

_____

_____
Employee's signature is required if you choose to **RE-DIRECT MAIL to Designated Representative.**

_____

SIGNATURE of Designated Representative:_____

Designated Representative:

_____
Address

_____ _____
Phone Number Email Address

► **ADMINISTRATOR WILL REQUIRE VERIFICATION OF DESIGNATED REPRESENTATIVE'S IDENTITY. YOUR DESIGNATED REPRESENTATIVE MUST HAVE THIS IDENTIFIER TO DISCUSS OR OBTAIN INFORMATION ON THE PATIENT(S).** See next page to assign Personal Identification Number.

I understand that I may revoke this Authorization at any time upon written or verbal request to the Administrator.

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PERSONAL IDENTIFICATION FORM

MEMBER'S NAME:_____

DESIGNATED REPRESENTATIVE NAME:_____

Please complete and return one copy with the Designated Representative Form. Failure to fully complete and return the Designated Representative form and one copy of this Personal Identification form will result in non-acknowledgement of the Designated Representative Authorization.

DESIGNATED REPRESENTATIVE PERSONAL IDENTIFICATION NUMBER

► _____ _____ _____ _____

Provide 4 numbers above to represent your personal identification number.

Please select and answer **two** of the following questions. This will allow the Administrator to verify your identity in the event you misplace or forget your Personal Identification Number.

1. What is the name of the street you grew up on?_____
2. What was the make/model of your first car?_____
3. What is your favorite color?_____
4. The last four numbers of your driver's license?_____
5. Other, provide your own question/answer?_____

_____

The Personal Identifier is designed for the purposes of protecting your privacy and that of the person for which you are the Designated Representative, per the requirements of HIPAA (Health Insurance Portability and Accountability Act). The administrator performs all reasonable efforts to validate the identity of each caller. Knowledge of your Personal Identification Number and/or the answers to two of the five questions above will be considered adequate information to identify the caller as the Designated Representative. For this reason, please do not share your identifiers with anyone.

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Keep this copy for your future use.

PERSONAL IDENTIFICATION FORM

MEMBER'S NAME:_____

DESIGNATED REPRESENTATIVE NAME:_____

Please complete and return one copy with the Designated Representative Form. Failure to fully complete and return the Designated Representative form and one copy of this Personal Identification form will result in non-acknowledgement of the Designated Representative Authorization.

DESIGNATED REPRESENTATIVE PERSONAL IDENTIFICATION NUMBER

► _____ _____ _____ _____

Provide 4 numbers above to represent your personal identification number.

Please select and answer **two** of the following questions. This will allow the Administrator to verify your identity in the event you misplace or forget your Personal Identification Number.

6. What is the name of the street you grew up on?_____
7. What was the make/model of your first car?_____
8. What is your favorite color?_____
9. The last four numbers of your driver's license?_____
10. Other, provide your own question/answer?_____

_____

The Personal Identifier is designed for the purposes of protecting your privacy and that of the person for which you are the Designated Representative, per the requirements of HIPAA (Health Insurance Portability and Accountability Act). The administrator performs all reasonable efforts to validate the identity of each caller. Knowledge of your Personal Identification Number and/or the answers to two of the five questions above will be considered adequate information to identify the caller as the Designated Representative. For this reason, please do not share your identifiers with anyone.