Request for Representative

THIS FORM WILL ALLOW ME, TO DESIGNATE ANOTHER PERSON TO ACT AS MY REPRESENTATIVE.
I understand that by completing and signing this form, I am authorizing Arizona Priority Care (AZPC) to treat my representative as myself for the following interactions. The representative is allowed access to my Protected Health Information (PHI) to communicate with AZPC staff, and execute any other HIPAA member rights.
This **does not** allow my representative to make healthcare decisions on my behalf.

VERIFICATION

Identification of Member/Patient: The following information is needed for verification. Please complete all applicable items.

Name of Beneficiary/Patient: _____ Date of Birth: _____
Beneficiary/Patient address: _____
Beneficiary/Patient Phone #: _____
Medicare ID#: _____

REPRESENTATIVE INFORMATION

PLEASE ENTER YOUR REPRESENTATIVE INFORMATION IN THE SECTION BELOW.
Identification of Representative: The following information is needed to confirm that we are releasing the information to the authorized Representative.
Name of Representative: _____
Date of Birth of Representative: _____
Representative's Phone#: _____
Expiration date of this Authorization (if applicable): _____

VERIFICATION QUESTIONS FOR PERSONAL REPRESENTATIVE

In this section "you" and "your" refers to the Representative

To verify your identity as personal representative, you will be asked to provide the following information: **the name of the patient/beneficiary you are representing, address/phone# or Medicare identification number and the patient/beneficiary date of birth, as well as your own name and date of birth**.

SIGNATURE

I have read and understand the above information.
I understand that I may end or change this request by notifying AZPC in writing or by phone by contacting AZPC Customer Service @ 480-336-7444
Signature of Beneficiary or Legal Representative: _____
Date: _____

FAX or MAIL Completed Form to: Arizona Priority Care 585 N. Juniper Dr. Suite #200 Chandler, AZ 85226 (fax#) 480-499-8759

FOR OFFICE USE ONLY

Received by (name): _____ **Date Received:** _____