Horizon Casualty Services, Inc.

RESET

Request for Appointment of Limited Representative for Claimant

Use this form if you wish to allow your personal health information with regards to your workers' compensation or personal injury protection claim to be disclosed to the person named below. Read instructions on page 2 before completing this form. ALL FIELDS MUST BE COMPLETED.

A separate form is required for each new authorized contact. Please print legibly, except when a signature is required. Please complete the information below, sign in the space provided and email (preferred) the form to HCS_Inquiry@HorizonBlue.com. Fax submissions can be sent to **1-973-854-6354**. Mail: Horizon Casualty Services, Inc., Attn: Customer Service, PO Box 10175, Newark, NJ 07101-3175

Claimant's Information

Name: _____

Claim Number: _____

Date of Birth: ___ / ___ / _____ Telephone #: ____ - ____ -_____
MM DD YYYY

Street Address on File: _____

City: _____ State: _____ Zip: _____

I, _____ , hereby acknowledge _____
(Claimant) *(Limited Representative)*

as my limited representative. I understand this request applies to communications from Horizon Casualty Services, Inc. and its business associates about my private information.

Information that Horizon Casualty Services, Inc. may disclose:

I authorize Horizon Casualty Services, Inc. to disclose the following information to my limited representative:

☐ Option 1: **All my information, including potentially sensitive information.** This may include a *diagnosis* (name of illness or condition), *procedure* (type of treatment), *claims, the name of my doctors and other health care providers*, and *financial information* (like billing and banking). Horizon Casualty Services, Inc. is permitted to disclose information related to HIV or AIDS, sexually transmitted disease, mental or behavioral health, substance abuse disorders (including alcohol abuse), genetic information, and sexual health (family planning & contraception, abortion, and pregnancy).

☐ Option 2: **All my information, BUT NOT sensitive information.** Horizon Casualty Services, Inc. is NOT permitted to disclose sensitive information, which may include a *diagnosis* (name of illness or condition), *procedure* (type of treatment), or *claims payment message that relates* to HIV or AIDS, sexually transmitted disease, mental or behavioral health, substance abuse disorders (including alcohol abuse), genetic information, and sexual health (family planning & contraception, abortion, and pregnancy). Please be advised that Horizon Casualty Services, Inc. will disclose the name of your doctors and other health care providers, which may be an indication of a sensitive service, to your Limited Personal Representative.

Horizon
Horizon Casualty Services, Inc.

Limited Representative Information *(required for privacy verification purposes)*

Name (Last, First, MI): _____

Last 4 Digits of Social Security#: _____ Date of Birth *(MM/DD/YYYY)*: ___ / ___ / _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone #: ____ - ____ -_____ Relationship to the claimant: _____

Time Period for Representation:

From: _____ / _____ / _____ To: _____ / _____ / _____
MM DD YYYY *MM DD YYYY*

NOTE: If no time period is provided, this request will remain in effect until the claimant or his/her limited representative notifies Horizon Casualty Services, Inc. in writing to request a change.

I have read the contents of this form. I understand, agree, and allow Horizon Casualty Services, Inc. (HCS) to discuss and/or disclose my information as I have stated above. I understand that I may revoke this authorization at any time by notifying HCS in writing at the address provided above. I understand that a revocation will not apply to information that was already disclosed. I understand that once information has been disclosed according to these instructions, the information is not protected by new or existing privacy laws.

Claimant Signature: _____ Date: ___ /___ /_____
MM DD YYYY

Printed Name: _____

The appointment will be effective on the date that HCS processes and approves the form.

General Instructions: All fields are required to be completed unless otherwise specified.
Use this form if you wish to allow your personal health information to be disclosed to another person.

Claimant's Information Section:
This section requests information related to the claimant for which a limited representative is being requested. Since this information is used for both identification and verification purposes, the information included in this section should match the most current information for the claimant that Horizon Casualty Services, Inc. has on file. Please, be aware that this form may be denied if the information on the form does not match the information in our records.

Limited Representative Information Section:
The requested information in this section will be used by Horizon Casualty Services, Inc. for identification and verification purposes. The limited representative will be required to verify this information during a phone call if they wish to receive your personal health information. Time Period of Representation: If no termination date is entered, the request will remain in effect until claimant notifies the change to Horizon Casualty Services, Inc. in writing.

Email signed/completed forms to: HCS_Inquiry@HorizonBlue.com. Fax submissions: **1-973-854-6354**.