



Request for Personal Representative

Instructions:

To ask for a Personal Representative, please fill out the information below, sign and print at the bottom of the form and return to:

Horizon NJ TotalCare (HMO SNP)

Attn: SNP Department

Address: 250 Century Parkway, Mt. Laurel, NJ 08054

A separate form is required for each member on the policy or coverage, as applies. Please write neatly.

Member Information: (circle whether request is for subscriber or dependent)

Name (Subscriber/Dependent): _____

Member ID #: _____

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

Address: _____

City: _____ State: _____ ZIP: _____

I, _____, hereby appoint _____ to be
(Name) (Personal Representative)

designated as my personal representative. I understand this request applies to communications from Horizon and its business associates about my private information. I also understand that mental health and/or substance abuse private information may be disclosed if I have utilized such services.

Time Period for Representation: From: ____ / ____ / ____ To: ____ / ____ / ____
MM DD YYYY MM DD YYYY

NOTE: If no time period is supplied, this request will stay in effect until the member or his/her legal representative notifies Horizon in writing asking for a change.

Purpose of Representation: (select one)

- Account Inquiries Only:** This means that Horizon is allowed to disclose private information to the person chosen. This person would have access to information such as: claims, enrollment and appeals etc.
- Correspondence and Account Inquiries:** Not only can Horizon disclose private information to the person chosen, but he/she will receive all correspondence that would in most cases go to the member, including, EOBs, checks, etc. For that reason, this option should ONLY be chosen if the member is sure he/she no longer wants to receive relevant coverage information directly, since the Personal Representative will receive it instead (generally, only in times of incapacity or incompetence (adults), or in the representation of a child; typically not for spouse-to-spouse representation).

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Personal Representative Information: (required for privacy verification purposes)

Name (Last, First, MI): _____

Last 4 Digits of Social Security #: _____ Date of Birth: ____ / ____ / ____
MM DD YYYY

Address: _____

City: _____ State: _____ ZIP: _____

Telephone #: _____ - _____ - _____ Relationship to the member: _____

NOTE: If the representative is court-ordered or has another legal designation (examples: power of attorney, living will, executor or administrator of probate estate), you must attach/include a copy of the official document(s) if not already supplied. If you are a documented legal representative, you may make this Request and sign this form below for the member.

Check here if you want your response to this request sent via email.

Email address: _____

Signature of Member / requestor: _____ Date: ____ / ____ / ____
(check whether member or other requestor) MM DD YYYY

Printed Name: _____

Horizon NJ TotalCare (HMO SNP) is an HMO Medicare Advantage Dual Special Needs plan with a Medicare contract and a contract with the State of New Jersey Medicaid Program. Enrollment in Horizon NJ TotalCare (HMO SNP) depends on contract renewal. Products are provided by HHNJ and Horizon Blue Cross Blue Shield of New Jersey, both of which are independent licensees of the Blue Cross and Blue Shield Association. Communications are issued by Horizon Blue Cross Blue Shield of New Jersey in its capacity as administrator of programs and provider relations for all its companies. The Blue Cross® and Blue Shield® names and symbols are registered marks of the Blue Cross and Blue Shield Association. The Horizon® name and symbols are registered marks of Horizon Blue Cross Blue Shield of New Jersey. © 2018 Horizon Blue Cross Blue Shield of New Jersey, Three Penn Plaza East, Newark, New Jersey 07105.