HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

This is not a Durable Power of Attorney for Health Care Decisions

This authorization is voluntary. The information you authorize us to disclose may be subject to re-disclosure by the recipient and if the person or organization authorized to receive the information is not a health plan or health care provider, the information may no longer be protected by the Federal privacy regulations.

You have the right to revoke any written authorization, except to the extent that we have taken action in reliance on the authorization, by writing to us at Sierra Health and Life Insurance Company, Inc., Attn. Member Services Department, P. O. Box 15645, Las Vegas, NV 89114-5645. We may not condition your receipt of treatment, payment, enrollment, or eligibility for benefits on completion of this authorization.

ALL FIELDS MUST BE COMPLETED. See instructions on reverse.

1. **Member Name** (one member per form): _____
   (Please print)
2. **Member Number**: _____
3. **I authorize Sierra Health and Life Insurance Company, Inc. ("SHL") to disclose my Protected Health Information designated in #4 below to the following person or organization:**

   Name of individual or entity: **Associated Benefit Consultants** **Carlton Combs, Mike Ashbaugh, Kelli Combs**

   604 South Jones Blvd. | Las Vegas | Nevada | 89107
   Address | City | State | Zip code

   702-870-6800 | 702-870-3345
   Phone | Fax
4. **I authorize SHL to disclose:**

   ☑ Information regarding eligibility, benefits, claim adjudication, prior authorization status and primary care physician assignment **AND/OR**

   ☑ The following specific information*: To obtain Explanation of Benefits, to obtain and assist with claims, eligibility and benefit questions, to file documents and forms regarding my health coverage, including but not limited to; Claims Issues, Prior Authorizations, Complaints, Appeals, Grievance and External Independent Review Organization.

   ***Information pertaining to substance abuse diagnosis or treatment requires completion of the Consent for Release of Confidential Health Information under 42 C.F.R. Part 2 - Confidentiality of Alcohol and Drug Abuse Patient Records.**
5. **Purpose of the disclosure**: I understand that the information designated in #4 above is being disclosed by SHL at my request.
6. **This authorization shall remain in effect from the date signed below until** (check only one):
   - ☑ Date of my disenrollment from the health plan
   - ☐ One year from the date this authorization is signed
   - ☐ Specific expiration date (MM/DD/YY): _____
   - ☐ Once the following event occurs: _____
7. **Member's Signature**: _____ **Date**: _____

   Personal Representative's signature: _____ Date: _____
   (if member is a minor and no sensitive health information is being disclosed or if the member is legally incapacitated)

   _____ _____
   Print name | Relationship to member

   Legal Authority: _____
   Documentation of the personal representative's legal authority must be attached.

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

INSTRUCTION SHEET

The numbers on this instruction sheet directly correspond to the numbers on the authorization form (i.e., #1 on this sheet provides instruction on how to fill out line 1. on the authorization form).

#1 Please print legibly, your full name (first name, last name). Enter only one member name per form.

#2 Write in your 11-digit identification number (may be called the Member # or Medical Identification # on your ID card). Enter only one member number per form.

#3 Write in the name of the person or organization you authorize us to disclose this information to. Please include the full name (i.e. first name, last name) and address of the individual or organization and print legibly.

#4 You must specify what information you want HPN to disclose. You can check the first box for information regarding eligibility, benefits, claims adjudication, prior authorization status and primary care physician assignment **AND/OR** you can indicate other information you want disclosed by checking the second box and writing the specific information in the space provided. You can choose one or both options.

Information pertaining to substance abuse diagnosis or treatment is protected by Federal confidentiality rules (42 C.F.R. Part 2). Disclosure of such information requires completion of the Consent for Release of Confidential Health Information under 42 C.F.R. Part 2 – Confidentiality of Alcohol and Drug Abuse Patient Records.

#5 By signing this authorization, you certify that you understand that this information is being disclosed by HPN at your request.

#6 You have a choice of how long the authorization remains in effect. Please select *only one* option.
If you select a specific expiration date or event, you must include additional details such as the specific date (i.e., 12/31/2008 or 01/01/2999) or specific event (i.e., until I am released from my inpatient stay at Valley Hospital). **Please note the following are examples of unacceptable expiration dates: "No expiration date", "Forever" and/or "Infinity".**

#7 The signature of the individual member and date is required. If the authorization form is signed by a personal representative of the member, the personal representative must provide legal documentation that he/she is authorized to act on the member's behalf.

****PLEASE REMEMBER TO KEEP THE YELLOW COPY****

ALL FIELDS MUST BE COMPLETED. An incomplete authorization form is invalid and will not be accepted. If you need additional assistance filling out the form or have any questions, please call Member Services. Member Services phone number can be found on the back of your ID card.

AUTHORIZATION TO APPOINT A REPRESENTATIVE

As a member of Health Plan of Nevada or Sierra Health & Life, you have the right to appoint a representative during the appeal/grievance process. Your representative may be, but not limited to a relative, friend, broker or attorney. Should you choose to assign a third party person to represent you during the appeal/grievance process, please complete and sign the following "Third Party Authorization Release" form.

Please return this completed and signed to:

Health Plan of Nevada / Sierra Health and Life Insurance, Inc.
Customer Response and Resolution Department

P.O. Box 14865, NV017-3020 - Las Vegas, Nevada 89114 – 4865
Fax Number: (702) 266-8813

Health Plan of Nevada / Sierra Health and Life Insurance Company, Inc.
Third Party Authorization Release

I, _____ do hereby authorize:
Print: Member/Subscriber Name

(Third Party Person Information)

Name of Person/Firm: **Associated Benefit Consultants**, Carlton Combs, Mike Ashbaugh, Kelli Combs

Address: 604 South Jones Blvd

Las Vegas, Nevada 89107

Telephone/Fax: 702-870-6800 - 702-870-3345

to represent me/or, _____, during the appeals process and/or at the Grievance Committee Hearing.

In addition, I authorize the Customer Response and Resolution Department to release all information/medical records if applicable to the members, participants of the Grievance Committee and above referenced Third Party Person, for the purpose of reviewing this case/issue.

_____ _____
(Print – Member or Subscriber Name) (date) Member Number

_____
(Signature – Member or Subscriber) (date)

_____
(Guardian Signature) If patient is a minor (date)

COVERED INDIVIDUAL'S WRITTEN DESCRIPTION OF DECISION IN DISPUTE

Please describe in your own words the disagreement with the denied service/claim(s).

Indicate clearly the service(s) that is being denied and the specific date(s) being denied. Explain why you disagree and attach any additional pages if necessary.

Include available and pertinent medical records, any information you received concerning the denial, any pertinent peer literature or clinical studies and any additional information from your physician/health care provider that you want included in the reconsideration of the denied service/claim(s).