Instructions for completing the Beneficiary Authorization Form

If you have any questions, please feel free to call us at the Beneficiary Services number on your beneficiary identification card. Please read the following to complete page one of the form.

Part A: Beneficiary information

This section applies to the beneficiary who is asking for the release of his or her information to another person or company.

1. Write your last name, first name, and middle initial.
2. Write your date of birth in this format: mmddyyyy. (If you were born on October 5, 1960, you would write 10051960.)
3. Write your full street address, city, state, and ZIP code.
4. Write your daytime phone number (including area code.)
5. Write your cell/mobile number (including area code.)
6. Identification number
   You will find this number on your beneficiary identification card.
7. Group number
   You will find this number on your beneficiary identification card. If your identification card does not have a group number leave this blank.

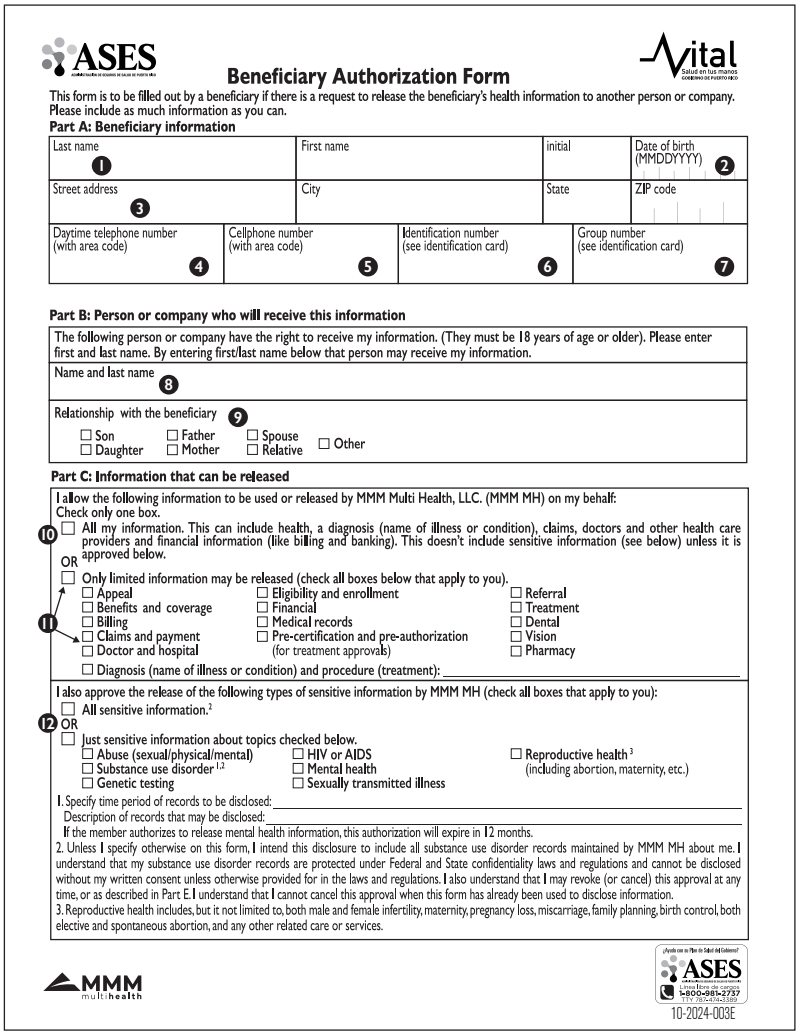
Part B: Person or company who will receive this information

8. Write the full name of the person or company that you want us to give your information to. Please don't use a general term like "my daughter" or "my son" as it will not be accepted.
9. Choose the relationship with you of the person that you are authorizing in this document.

Part C: Information that can be released

This section tells us what information you would like us to release: all or just some.

10. For "all of your information," check the first box.
11. For "limited information," check the second box and the boxes that apply to you.
12. Some topics may be very personal or sensitive to you. If you wish to approve the release of this type of information, check the box(es) that apply to you.



ASES

Beneficiary Authorization Form

Vital Salud en tus manos GOBIERNO DE PUERTO RICO

This form is to be filled out by a beneficiary if there is a request to release the beneficiary's health information to another person or company. Please include as much information as you can.

Part A: Beneficiary information

Last name 1	First name	initial	Date of birth (MMDDYYYY) 2
Street address 3	City	State	ZIP code

Daytime telephone number (with area code) 4	Cellphone number (with area code) 5	Identification number (see identification card) 6	Group number (see identification card) 7

Part B: Person or company who will receive this information

The following person or company have the right to receive my information. (They must be 18 years of age or older). Please enter first and last name. By entering first/last name below that person may receive my information.

Name and last name 8

Relationship with the beneficiary 9

☐ Son ☐ Father ☐ Spouse ☐ Other
☐ Daughter ☐ Mother ☐ Relative

Part C: Information that can be released

I allow the following information to be used or released by MMM Multi Health, LLC. (MMM MH) on my behalf:
Check only one box.

10 ☐ All my information. This can include health, a diagnosis (name of illness or condition), claims, doctors and other health care providers and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below.

OR

☐ Only limited information may be released (check all boxes below that apply to you).

11
☐ Appeal ☐ Eligibility and enrollment ☐ Referral
☐ Benefits and coverage ☐ Financial ☐ Treatment
☐ Billing ☐ Medical records ☐ Dental
☐ Claims and payment ☐ Pre-certification and pre-authorization ☐ Vision
☐ Doctor and hospital (for treatment approvals) ☐ Pharmacy
☐ Diagnosis (name of illness or condition) and procedure (treatment): _____

I also approve the release of the following types of sensitive information by MMM MH (check all boxes that apply to you):

12 ☐ All sensitive information.[2]

OR

☐ Just sensitive information about topics checked below.
☐ Abuse (sexual/physical/mental) ☐ HIV or AIDS ☐ Reproductive health[3] (including abortion, maternity, etc.)
☐ Substance use disorder[1,2] ☐ Mental health
☐ Genetic testing ☐ Sexually transmitted illness

1. Specify time period of records to be disclosed: _____
Description of records that may be disclosed: _____
If the member authorizes to release mental health information, this authorization will expire in 12 months.
2. Unless I specify otherwise on this form, I intend this disclosure to include all substance use disorder records maintained by MMM MH about me. I understand that my substance use disorder records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time, or as described in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.
3. Reproductive health includes, but it not limited to, both male and female infertility, maternity, pregnancy loss, miscarriage, family planning, birth control, both elective and spontaneous abortion, and any other related care or services.

MMM multihealth

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10-2024-003E

MMM multihealth

¿Ayuda con su Plan de Salud del Gobierno? ASES ADMINISTRACIÓN DE SEGUROS DE SALUD DE PUERTO RICO Línea libre de cargos 1-800-981-2737 TTY 787-474-3389

10-2024-003E

Please read the following for help completing page two of the form.

Part D: Purpose of this approval

This section tells us the reason you've asked for the release of your information.

1. Check the first box to let us know that we can give out this information as shown on this form.
2. Check the second box for a specific reason. An example might be to settle a life insurance claim.

Part E: Date your approval expires

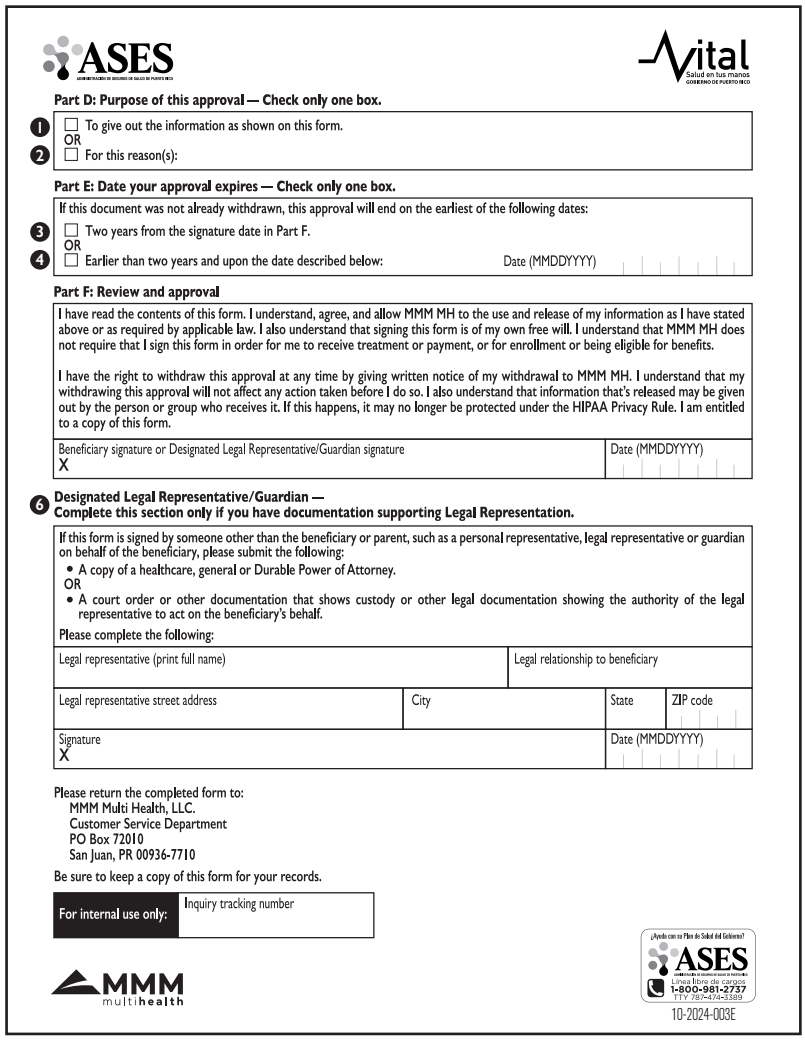
You have two choices of when you would like this approval to end.

3. Check the first box for the standard 2 years that it will end.
4. Check the second box for an earlier date (other than 2 years), and give the date you wish this approval to end.

Your authorization/approval can't be granted for more than 2 years.

Part F: Review and approval

5. Sign your name and put the date on the form. Your name and signature must match the information in Part A.
6. If you are signing this form on behalf of another person, or if you have Power of Attorney for healthcare, or are a legal guardian/conservator you must do the following:
   - You must complete the Designated Legal Representative/Guardian section.
   - You must also provide us with a copy of the legal document showing that you are approved and include it with this form.



ASES — Administración de Seguros de Salud de Puerto Rico

Vital — Salud en tus manos — Gobierno de Puerto Rico

Part D: Purpose of this approval — Check only one box.

1 ☐ To give out the information as shown on this form.

OR

2 ☐ For this reason(s):

Part E: Date your approval expires — Check only one box.

If this document was not already withdrawn, this approval will end on the earliest of the following dates:

3 ☐ Two years from the signature date in Part F.

OR

4 ☐ Earlier than two years and upon the date described below: Date (MMDDYYYY)

Part F: Review and approval

I have read the contents of this form. I understand, agree, and allow MMM MH to the use and release of my information as I have stated above or as required by applicable law. I also understand that signing this form is of my own free will. I understand that MMM MH does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to MMM MH. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Beneficiary signature or Designated Legal Representative/Guardian signature	Date (MMDDYYYY)
X	

6 **Designated Legal Representative/Guardian — Complete this section only if you have documentation supporting Legal Representation.**

If this form is signed by someone other than the beneficiary or parent, such as a personal representative, legal representative or guardian on behalf of the beneficiary, please submit the following:

- A copy of a healthcare, general or Durable Power of Attorney.

OR

- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the beneficiary's behalf.

Please complete the following:

Legal representative (print full name)	Legal relationship to beneficiary		
Legal representative street address	City	State	ZIP code
Signature X			Date (MMDDYYYY)

Please return the completed form to:
MMM Multi Health, LLC.
Customer Service Department
PO Box 72010
San Juan, PR 00936-7710

Be sure to keep a copy of this form for your records.

For internal use only:	Inquiry tracking number

MMM multihealth

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10-2024-003E

Examples of legal documents:

- Healthcare, General or Durable Power of Attorney. This document gives someone you trust the legal power to act on your behalf and make health care decisions for you.
- Legal Guardianship. This is when the court appoints someone to care for another person.
- Conservatorship. This happens when a judge appoints a responsible person to make decisions for someone who can't make responsible decisions for him/herself.
- Executor of estate. This type of document would be used when the person who is being represented has died.

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10-2024-003E

Beneficiary Authorization Form

This form is to be filled out by a beneficiary if there is a request to release the beneficiary's health information to another person or company. Please include as much information as you can.

Part A: Beneficiary information

Last name	First name	initial	Date of birth (MMDDYYYY)
Street address	City	State	ZIP code

Daytime telephone number (with area code)	Cellphone number (with area code)	Identification number (see identification card)	Group number (see identification card)

Part B: Person or company who will receive this information

The following person or company have the right to receive my information. (They must be 18 years of age or older). Please enter first and last name. By entering first/last name below that person may receive my information.

Name and last name

Relationship with the beneficiary

☐ Son ☐ Daughter ☐ Father ☐ Mother ☐ Spouse ☐ Relative ☐ Other

Part C: Information that can be released

I allow the following information to be used or released by MMM Multi Health, LLC. (MMM MH) on my behalf:
Check only one box.

☐ All my information. This can include health, a diagnosis (name of illness or condition), claims, doctors and other health care providers and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below.

OR

☐ Only limited information may be released (check all boxes below that apply to you).

- ☐ Appeal
- ☐ Benefits and coverage
- ☐ Billing
- ☐ Claims and payment
- ☐ Doctor and hospital
- ☐ Eligibility and enrollment
- ☐ Financial
- ☐ Medical records
- ☐ Pre-certification and pre-authorization (for treatment approvals)
- ☐ Referral
- ☐ Treatment
- ☐ Dental
- ☐ Vision
- ☐ Pharmacy

☐ Diagnosis (name of illness or condition) and procedure (treatment): _____

I also approve the release of the following types of sensitive information by MMM MH (check all boxes that apply to you):

☐ All sensitive information.[2]

OR

☐ Just sensitive information about topics checked below.

- ☐ Abuse (sexual/physical/mental)
- ☐ Substance use disorder [1,2]
- ☐ Genetic testing
- ☐ HIV or AIDS
- ☐ Mental health
- ☐ Sexually transmitted illness
- ☐ Reproductive health [3] (including abortion, maternity, etc.)

1. Specify time period of records to be disclosed: _____
Description of records that may be disclosed: _____
If the member authorizes to release mental health information, this authorization will expire in 12 months.

2. Unless I specify otherwise on this form, I intend this disclosure to include all substance use disorder records maintained by MMM MH about me. I understand that my substance use disorder records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time, or as described in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

3. Reproductive health includes, but it not limited to, both male and female infertility, maternity, pregnancy loss, miscarriage, family planning, birth control, both elective and spontaneous abortion, and any other related care or services.

Part D: Purpose of this approval — Check only one box.

☐ To give out the information as shown on this form.
OR
☐ For this reason(s):

Part E: Date your approval expires — Check only one box.

If this document was not already withdrawn, this approval will end on the earliest of the following dates:

☐ Two years from the signature date in Part F.
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I have the right to withdraw this approval at any time by giving written notice of my withdrawal to MMM MH. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Beneficiary signature or Designated Legal Representative/Guardian signature X	Date (MMDDYYYY)

Designated Legal Representative/Guardian —
Complete this section only if you have documentation supporting Legal Representation.

If this form is signed by someone other than the beneficiary or parent, such as a personal representative, legal representative or guardian on behalf of the beneficiary, please submit the following:

- A copy of a healthcare, general or Durable Power of Attorney.

OR

- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the beneficiary's behalf.

Please complete the following:

Legal representative (print full name)	Legal relationship to beneficiary		
Legal representative street address	City	State	ZIP code
Signature X		Date (MMDDYYYY)	

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