Personal Representative Authorization Form: Filing an Appeal, a Grievance or a Request for Service

About this form

You may submit this Personal Representative Authorization (PRA) if you would like to designate a Personal Representative to act on your behalf. If a Personal Representative signed your application for you, or if you are a Personal Representative applying on behalf of someone else, you **must** submit this form for the application to be processed.

Note: A Personal Representative designated through this form has the authority to act on an applicant's or member's behalf in all matters with Fallon Health, and will receive personal information about the applicant or member until we receive a cancellation notice terminating their authority. Their authority will not automatically terminate once we process your application.

If you would like, you can choose someone to help you.

You may choose a Personal Representative to help you get health care coverage through programs offered by Fallon Health by completing this form. However, you or a representative can sign for yourself and for any of your dependent children under the age of 18 for whom you are the custodial parent. You are not required to have a representative in order to apply for or receive benefits.

Who can help me?

1. A Personal Representative can be a friend, family member, relative, or other person or organization of your choosing who agrees to help you. It is up to you to choose a Personal Representative if you want one. Fallon Health will NOT choose a Personal Representative for you. To select a Personal Representative:
    a. You must designate the person or organization in writing, by filling out Section I, Part A of this form, who you want to be your Personal Representative.
    b. Your Personal Representative must also fill out Section I, Part B.
    c. You must fill out a separate PRA form if you want to name more than one person or organization to serve as Personal Representative.

2. A person appointed by law to act on behalf of the estate of an applicant or member who has died can also serve as a Personal Representative by following the instructions above. This type of Personal Representative may be a legal guardian authorized to make medical decisions, holder of a durable power of attorney, or health care proxy, or, if the applicant or member has died, the estate's administrator or executor. What this person is authorized to do for you or for the applicant or member's estate will depend on the wording of the legal appointment. This person completes information in Section II of this form and is referred to as a Section II Personal Representative.

What can a Personal Representative do?

A Personal Representative may

- Fill out your application or eligibility review forms;
- Fill out other Fallon Health eligibility or enrollment forms;
- Give proof of information reported on these forms;

- Report changes in income, address, or other circumstances;
- Get copies of all of your Fallon Health eligibility and enrollment notices; and
- Act on your behalf in all other matters with Fallon Health including filing an appeal, a grievance or a request for service.

How does a Personal Representative designation end?

If you decide that you no longer want a Personal Representative, you must notify us at the time you want the designation to end by mailing a letter notifying us that the designation has ended to:

Fallon Health
Privacy Coordinator
10 Chestnut St.
Worcester, MA 01608
or
Fax: 1-508-831-1136

The notice must include:

- Your name
- Your address
- Date of birth
- The name of your Personal Representative
- A statement that the designation has ended
- Your signature or the signature of someone acting on your behalf (in the case of a Section II Personal Representative only).

In addition, if your Personal Representative notifies us that they are no longer acting on your behalf, we will no longer recognize that person or organization as your Personal Representative.

A **Section II** Personal Representative's designation ends when his or her legal appointment ends. The Personal Representative must notify us as instructed above.

In addition, a Personal Representative's designation for a minor child ends on the date the child turns 18.

How do I submit this form?

You must send the PRA form to the following:

Fallon Health
Privacy Coordinator
10 Chestnut St.
Worcester, MA 01608
or
Fax: 1-508-831-1136

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Section I – Member, Applicant and Personal Representative Information.

Part A—to be filled out by applicant or member. Please print, except for signature.

Member/Applicant Information:

First name:	Middle initial:	Last name:	
Street address:	City:	State:	ZIP code:
Date of birth:	Telephone:	Fallon member ID number:	

I certify that I have chosen the following person or organization to be the Personal Representative for myself and any dependent children under the age of 18 for whom I am the custodial parent and that I understand the duties and responsibilities this person or organization will have (as explained earlier in this form). I understand that when the person or organization named below gets this information from Fallon Health, that person or organization may be able to share it with others without my permission. If they do so, federal and state privacy laws may not protect the information.

Signature of member or applicant _____ Date _____

Personal Representative Information:

First name:	Middle initial:	Last name:	
Name of Organization *(if applicable):*			
Street address:	City:	State:	ZIP Code:
Telephone:	Email address:		

Part B—to be filled out by the Personal Representative. Please print, except for signature.

B1. Complete if Personal Representative is an individual.

I certify that I will at all times maintain the confidentiality of any information regarding the applicant or member set forth above and, if applicable, the dependent children of such applicant or member, that is provided to me by Fallon Health.

If I am also a provider, staff member, or volunteer affiliated with an organization, and I am acting in my own capacity, and not on behalf of any organization, in connection with my designation as a Personal Representative, I certify that I will at all times adhere to all applicable state and federal laws and regulations regarding confidentiality of information and conflicts of interest including those set forth at 201 CMR 17.00, 42 C.F.R. part 431, subpart F, 42 C.F.R. § 447.10, 45 C.F.R. § 155.260(f) and 45 CFR Part 164.

Signature of Personal Representative _____ Date _____

Personal Representative's printed name:	Email address:

B2. Complete if Personal Representative is an organization.
I certify, on behalf of the organization set forth below, that such organization will at all times maintain the confidentiality of any information regarding the applicant or member set forth above and, if applicable, the dependent children of such applicant or member, that is provided to the organization by Fallon Health.

I, the provider, staff member, or volunteer of the organization set forth below, completing this form, certify on behalf of myself and on behalf of the organization I represent, that any providers, staff members, or volunteers acting on behalf of the organization in connection with this Personal Representative designation will at all times adhere to all applicable state and federal laws and regulations regarding confidentiality of information, and conflicts of interest, including those set forth at 201 CMR 17.00, 42 C.F.R. part 431, subpart F, 42 C.F.R. § 447.10, and 45 C.F.R. § 155.260(f) and 45 CFR Part 164.

Signature of provider, staff member, or volunteer completing form	Date

Printed name of provider, staff member, or volunteer completing form:	Email address:
Personal Representative Organization name:	

Section II. Signature if person filling out the form is someone other than the member or applicant.

Printed name of person filling out the form:

First name:	Middle initial:	Last name:	
Street address:	City:	State:	ZIP Code:
Telephone:	Email address:		

Signature of person filling out the form	Date

Authority of person filling out this form to act on behalf of the applicant or member:*

☐ Parent or guardian of a minor child ☐ Guardian authorized to make health care decisions
☐ Health Care Proxy ☐ Holder of a durable power of attorney

*If this form is being filled out by someone who has been appointed by a court as a legal guardian, or who is a holder of a durable power of attorney or health-care proxy, a copy of the applicable legal document must be attached.

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