FLORIDA HOSPITAL CARE ADVANTAGE

Health First Health Plans

6450 US Highway 1
Rockledge, Florida 32955
myFHCA.org

APPOINTMENT OF REPRESENTATION

Member Name: _____ **Plan ID Number**: _____

Named Representative: _____

I swear that I am either the member named above or their legal representative (attach documentation). With my signature below, I permit my "Named Representative" to perform the following activities on my behalf until I specifically request otherwise.

Activity (check all that apply):	Special Instructions:	Effective Date:
❑ Filing a Grievance or Appeal *(non-Medicare members only)*		
❑ Choosing my providers		
❑ Accessing my enrollment information		
❑ Accessing my financial information		
❑ Accessing my claims and authorizations		
❑ Accessing my medical information		
❑ Other (please specify):		
❑ **ALL OF THE ABOVE**		

Member Signature: _____ **Date**: _____

Representative Signature: _____ **Date**: _____

***Please return this completed form to**:* Florida Hospital Care Advantage, Attn: Enrollment, 6450 US Highway 1, Rockledge, FL 32955, Fax: 321.434.4226

Uses and disclosures of protected health information not covered by the *Notice of Privacy Practices** or other applicable laws will be made only with your written permission. If you provide us permission to use and disclose your protected health information, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose your protected health information for the reasons covered by your written permission. We are unable to take back any disclosures we have already made with your permission, and must retain our records of services provided to you. If we disclose information to your personal representative, we cannot guarantee that your personal representative will not further disclose the protected health information to a third party, and that state and federal laws may no longer protect such information. Completion of this form does not affect the continuation or quality of treatment by Health First, enrollment in the health plan, or eligibility for benefits. *The *Notice of Privacy Practices* can be found on our website at myFHCA.org or call Customer Service to request a copy.

Medicare Members: For assistance, call Customer Service toll-free at 1.855.882.6467 (TTY/TDD relay: 1.800.955.8771) weekdays from 8 a.m. to 8 p.m. and Saturdays from 8 a.m. to noon. From October 1 to February 14, we're available seven days a week from 8 a.m. to 8 p.m.

Individual & Group Members: For assistance, call Customer Service toll-free at 1.844.522.5279 (TTY/TDD relay: 1.800.955.8771) Monday through Friday from 8 a.m. to 5 p.m.

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