UPMC HEALTH PLAN/UPMC HEALTH NETWORK, INC.

Personal Representative Designation Form

Instructions

We have received your request to appoint a personal representative to act on your behalf in discussing your health information and benefit coverage through UPMC Health Plan/UPMC Health Network, Inc.

Your privacy is important to us. Please take a moment to provide the requested information about yourself and the person you are designating to act on your behalf concerning your health care benefits. Once you return this completed, signed, and dated form to us, we can verify your request, adjust our records accordingly, and speak to your personal representative.

Please read this form carefully, and fill it out completely. Please print or type. If printing, please use a pen.

❶ Required Information

Member name:	Member ID number:
Member address:	Date of birth:
Address of policyholder, *if different from above:*	Social Security number:
Phone number *(in case we need to contact you):*	
Name of member's designated representative:	Phone:
Address:	Fax:
Any limitations on issues your personal representative may discuss? Yes No If yes, please specify (*example: claims payment, pharmacy, etc.*):	
If you do not want this designation to expire, leave this section blank. If you do want it to expire, write in the expiration date here:	

❷ Required Signatures

Personal Representative Signature _____ Date _____

Member Signature _____ Date _____

In the event that the member is a minor or otherwise legally incompetent, please provide the name, address, and relationship to the member of the person who is signing the designation letter.

Name _____ Relationship _____

Address _____

Please return this completed form by mail to:
UPMC Health Plan/UPMC Health Network, Inc.
P.O. Box 2965
Pittsburgh, Pennsylvania 15230-2965

or by fax to:
412-454-7829

If you have any questions about this Personal Representative Designation form, please call the Member Services Department at the telephone number on the back of your ID card.

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