PAYFLEX®

Authorization to Release Personal Information

Fax Completed Form to: 1-402-978-3728
You may also mail a completed form to:
PayFlex Systems USA, Inc.
PO Box 981158
El Paso, TX 79998-1158

PLEASE READ THIS CAREFULLY. When you complete and sign this form, you give PayFlex Systems USA, Inc. (PayFlex) permission to release your personal information to another person or organization*. You name the Recipient below. Your personal information is related to your account at PayFlex. It may include but is not limited to claim information (provider name; if you need to substantiate a claim; amount; etc.); reimbursements that the account has paid; explanation of payment (EOP); receipt request letters; premiums that you pay; insurance carrier name; web access status; debit card status; bank account information; and general plan inquiries.

The federal privacy standards that protect your personal information may not apply to the Recipient you name below. This means that the Recipient may be able to give your information to others.

This authorization does have an expiration date. It ends twelve months after the end of your coverage in the plan. It will end on the last day of that twelve-month period. You can end this authorization if you want. You will have to send us written notice to do so. It will not affect any actions taken prior to when we receive your request.

This request is voluntary on your part. You do not have to do this. This has no impact on your eligibility for benefits; treatment you receive; your enrollment; or claim payments. The plan cannot ask or expect you to sign this form for any reason.

* Do not use this form so that your providers can file billing, claim or Explanation of Benefits (EOB) information or documentation. They do not need your signed authorization to submit billing or claim information.

Instructions

1. To authorize the release of personal information, complete sections A, B, C and E of this form. Return it to PayFlex.
2. To revoke or cancel an authorization, complete sections A, B and D of this form. Return it to PayFlex.
Note: We cannot process this form if it is not completed and signed. We also need any necessary documentation to process this form.

Section A – Member Information (Person whose information will be released.)

RECIPIENT WILL NEED TO HAVE ALL OF THIS INFORMATION WHEN CONTACTING PAYFLEX.

Member Name *(First, MI, Last)*	**Member Number** **OR** **Social Security Number** *(Last four digits only)* XXX-XX-		
Address	**City**	**State**	**ZIP Code**
Employer Name *(Previous employer if COBRA or Retiree Account)*	**Daytime Telephone** ( ) -		

Section B - Recipient Information (Person or organization that you authorize to receive Member information.)

MEMBER MUST COMPLETE A SEPARATE FORM FOR EACH RECIPIENT.

Recipient or Organization Name	**Relationship to Member** *(Select only one)* ☐ Spouse ☐ Adult Child ☐ Parent ☐ Friend ☐ *Legal Representative		
Address	**City**	**State**	**ZIP Code**

***Note: No additional documents must be submitted with this form, as long as the Member signs this form.** If the Member is unable to sign this form for the reasons outlined below, the Member's Legal Representative must provide one of the following:

1. If the Member is deceased, the Legal Representative must provide documentation that he or she is the executor or administrator of the Member's estate. We cannot rely on a Durable Power of Attorney, Advance Directive, Guardianship or Conservatorship papers after the death of the Member, as the powers are no longer valid.
2. If the Member is incapacitated and, as a result, a Legal Representative needs to act on behalf of the Member, submit this completed Authorization form and include the legal documentation showing who the Legal Representative is. Legal documentation includes a Durable Power of Attorney, Guardianship or Conservatorship papers.

Section C - Information To Be Released To Recipient (Select only one.)

☐ **Grant Full Account Privileges** – This gives the Recipient the same access as the Member. It allows the Recipient to receive all account information; submit claims and required documents; and make changes to the account. This includes resetting web login and password; requesting debit cards and changing account information.

☐ **Grant Limited Account Privileges** – This is for informational purposes only. It will not allow the Recipient to make or authorize account changes.

Section D - Revocation / Cancellation Request

Complete only when requesting PayFlex to revoke or cancel an authorization request. You must complete Sections A, B and D.
Until PayFlex receives and processes your request to cancel, the Recipient still has the access that you previously granted.

I wish to revoke/cancel account privileges for (Recipient Name)		
Member Name	**Signature**	**Date**

Section E - Signature

I request and authorize PayFlex to release my information to the Recipient named above. I understand that this may include protected health information (PHI). I understand that this authorization expires at the end of the twelve-month period following the end of my coverage. I also understand that this authorization will be in place until then, unless I send a written request to cancel it. I understand this request is voluntary for me. The plan cannot base my eligibility for benefits, treatment, enrollment or claims payment on this authorization. I also understand that once information is disclosed to the Recipient, the federal privacy standards protecting my health information may not apply to the Recipient. I understand that this means that the Recipient may be able to share this information.

Print Name	**Signature**	**Date**

Keep a copy of this completed form for your personal records