

**Assistance in Health Claims Administration**

To: Maine Municipal Employees Health Trust  
Subject: Authorization to release health information for claims administration or resolution

I, \_\_\_\_\_, authorize the Maine Municipal Employees Health Trust to  
*Member name*  
release and discuss my personal health information for the purpose of :

- Resolving questions about the payment/resolution of my health/dental/disability (circle applicable plan) claims
- Resolving questions about my specific claim (please specify provider, date and/or diagnosis):  
\_\_\_\_\_
- Resolving questions about my eligibility
- Other (please specify): \_\_\_\_\_  
\_\_\_\_\_

This health care information may be released to \_\_\_\_\_.  
*\*Authorized Person's name*

This authorization expires on \_\_\_\_\_. I acknowledge that I have received a  
*date or event - if applicable*  
written copy of this authorization and I understand that I am not required to sign this authorization as a condition of eligibility in the health plan or payment of benefits. I have read and understand all of the notices set forth below.

Employee Name \_\_\_\_\_ Employee SS# \_\_\_\_\_  
*Please print*

Member Signature \_\_\_\_\_

Date \_\_\_\_\_

**Important Notice Under HIPAA**

I, \_\_\_\_\_, understand that I may revoke this authorization at  
*Member name*  
any time by providing the Maine Municipal Employees Health Trust with written notice that I am revoking this authorization. I understand, however, that I may not revoke this authorization to the extent that \_\_\_\_\_ and Maine Municipal Employees Health  
*\*Authorized Person name*  
Trust have acted in reliance upon this authorization prior to the date I revoke this authorization.

I acknowledge that I have read and understand these notices.

Member Signature \_\_\_\_\_ Date \_\_\_\_\_

**\* Authorized Person** means the individual to whom you grant permission to speak with Health Trust personnel regarding your claim(s) and/or coverage. An Authorized Person can be an employee (in the case of a dependent completing this form), dependent, parent, co-worker, or any other person who may help you with claim and/or coverage issues.

**Individual Revocation of PHI Authorization**

I, \_\_\_\_\_, am notifying \_\_\_\_\_

*Member name*

*\*Authorized Person name*

and the Maine Municipal Employees Health Trust that I am revoking my authorization dated \_\_\_\_\_ for the Maine Municipal Employees Health Trust to release my health care information for the purpose of

\_\_\_\_\_

*(describe purpose of authorization)*

I understand that I cannot revoke any action already taken by \_\_\_\_\_

*\*Authorized person name*

and the Maine Municipal Employees Health Trust in reliance upon my authorization prior to the date of this revocation.

Member Name (please print) \_\_\_\_\_

Member Social Security Number \_\_\_\_\_

Member Signature \_\_\_\_\_ Date \_\_\_\_\_

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