

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/vision (circle applicable plans) 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.

Employee Name _____ Employee SS# _____

Please print

Member Signature _____

Date _____

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