PERSONAL REPRESENTATIVE APPOINTMENT FOR INTEROPERABILITY PURPOSES

This form is used to authorize Wellmark to disclose protected health information at the request of the individual.

* = Required

A. WHO IS APPOINTING THE PERSONAL REPRESENTATIVE

Are you appointing a personal representative for yourself? ☐ Yes ☐ No

If Yes, go to B

If No, select the appropriate box for your relationship to the member and fill out your name and address below.

- ☐ **Legal Guardian** - Wellmark will reference any legal guardian documentation on file when processing this appointment form. If you have not previously submitted your legal guardian documentation, please include it.
- ☐ **POA - Power of Attorney** - A POA must have authority to access medical records and protected health information to appoint a personal representative. Wellmark will reference any power of attorney (POA) documentation on file when processing this appointment form. If you have not previously submitted your power of attorney (POA) documentation, please include it.
- ☐ **Parent** - Upon submission of this appointment form, Wellmark will evaluate your relationship to the member for whom you are appointing a personal representative. If you are not on-file with Wellmark as a parent of this member, we suggest providing the legal documentation establishing your relationship to the member.

First Name*______________________________ Last Name*______________________________

Mailing Address Line 1*______________________________

Mailing Address Line 2______________________________

City*, State*______________________________ ZIP*______________

Email Address*______________________________

Please provide one of the following if you are a Wellmark member*:

Social Security Number______________________ OR

Wellmark ID#______________ AND last 4 digits of Social Security Number______________________

B. MEMBER WHOSE INFORMATION WILL BE RELEASED

First Name*______________________________ Last Name*______________________________

Date of Birth*_____/_____/_____

Please provide one of the following*:

Social Security Number______________________ OR

Wellmark ID#______________ AND last 4 digits of Social Security Number______________________

Mailing Address Line 1*______________________________

Mailing Address Line 2______________________________

City*, State*______________________________ ZIP*______________

Email Address______________________________

C. PERSONAL REPRESENTATIVE APPOINTMENT

I appoint the individual named below as Personal Representative for Interoperability Purposes for the member listed above, with Wellmark Health Plan of Iowa, Inc. and to have access to claims and encounter data concerning the member's interactions with health care providers and clinical data on and after the effective date of this appointment.

Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health Plan of Iowa, Inc., Wellmark Synergy Health, Inc., Wellmark Value Health Plan, Inc., and Wellmark Blue Cross and Blue Shield of South Dakota are independent licensees of the Blue Cross and Blue Shield Association.

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D. PERSONAL REPRESENTATIVE INFORMATION

Are you appointing yourself as the member's (named above) personal representative? ☐ Yes ☐ No

If Yes, go to "Effective" section

If No, fill out the following:

Personal Rep First Name*________________________________ Personal Rep Last Name*____________________________

Personal Rep Date of Birth*_____/_____/_____

Is this individual a Wellmark member? ☐ Yes ☐ No

If Yes,

Wellmark ID Number*________________________________ AND

Last 4 digits of Social Security Number*________________

If No,

Last 4 of Social Security Number*_____________________

Personal Rep Mailing Address Line 1*____

Personal Rep Mailing Address Line 2____

Personal Rep City, State*____ Personal Rep ZIP*________________

Personal Rep Email Address*____

Effective: This appointment of a Personal Representative for Interoperability Purposes is effective upon Wellmark's receipt of a fully completed and signed original or exact copy of this form at the address stated below.

Expiration: This appointment and authorization will expire 30 days after termination of the member's health plan coverage unless revoked or an earlier date is entered below.

☐ On_____/_____/_____ (Date MM/DD/YYYY)

On the member's 18th birthday, the personal representative will be effectively removed. A new appointment form will have to be submitted.

Right to Revoke:

☐ By checking this box and entering my signature on this appointment form, I understand that I may revoke this appointment and authorization at any time by giving written notice of my revocation to Wellmark at the address stated below or electronically by accessing Wellmark's website. I understand that revocation of this appointment and authorization will not affect any action taken in reliance on this appointment and authorization before Wellmark receives my written notice of revocation.

E. AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Protected Health Information to be Disclosed: I authorize Wellmark to disclose the protected health information described in this form to the named Personal Representative.

This authorization shall include and apply to any and all protected health information related to treatments where the individual has requested a restriction and/or for any health care item or service for which the health care provider has been paid out of pocket in full.

Effect of Granting this Authorization: I understand that if the person or entity that receives the information requested is not covered by federal or state privacy laws, the information described above may be redisclosed and will no longer be protected by law.

Prohibition on Redisclosure: This form does not authorize the disclosure of medical information beyond the limit of the authorization. Where information has been disclosed from the records protected by Federal law for alcohol/drug abuse records or state law for mental health records, the Federal requirements (42 CFR Part 2) and state requirements (Iowa Code Chapter 228 or South Dakota Codified Laws Chapter 27A-12) prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

F. AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION, CONT'D

No Conditions: This authorization is voluntary. Wellmark will not condition your enrollment in a health plan, eligibility for benefits or payment of claims on giving this authorization.

Specific Authorization for Mental Health, Substance Abuse Treatment or AIDS-Related Information:
I authorize and consent to the release and disclosure of any and all protected health information, as described in this form, including specifically mental health information, substance abuse (drug or alcohol), AIDS-related and genetic information, if applicable, to the individual named as long as this appointment of Representative is in effect. I understand that I may inspect the mental health information disclosed.

I have had full opportunity to read and consider the contents of this personal representative appointment and I understand that, by signing this form, I am confirming authorization of the disclosure of my protected health information, as described in this form. If this authorization involves the disclosure of mental health information, I acknowledge receipt of a copy of the authorization.

If this form was submitted electronically, your typed signature is as binding as a written signature.

Individual's Signature (or person submitting request)**:** ____ **Date**: _____/_____/_____

Name of Legal Guardian, attorney-in-fact or parent if applicable*: ____

**If a legal guardian or attorney-in-fact signs for an individual, a copy of the guardian appointment or medical Power of Attorney document must be submitted with this form.*

G. RETAIN A COPY FOR YOUR RECORDS

Send completed and signed form to:

Wellmark Blue Cross and Blue Shield
Privacy Office, Mail Station 5W590
PO Box 9232
Des Moines, IA 50306-9232

Or email to privacyoffice@wellmark.com

Or fax to (515) 376-9032

H. WHAT YOU WILL GET WHEN YOU REQUEST YOUR HEALTH INFORMATION

As an exchange member, you can connect your Wellmark health information to an application of your choice. This gives you a better picture of your health history and complete control over your health information in an effort called interoperability.

"Interoperability" is a long word, but its meaning is simple – it means more transparency for your health care. With interoperability, all the health systems that hold your health information – doctors, hospitals or clinics and insurance companies – are able to work together to deliver your whole health history. Knowing your whole health history means any doctor you see has a better picture of your health and can deliver more personalized care, at a lower cost.

Wellmark provides you with detailed information about your health history through a "Patient Access API," which allows you to easily access your health information through a third-party application (App) of your choice. The information available through the Patient Access API includes information we collect about you while you have been enrolled in a Wellmark health plan through the Marketplace since Jan. 1, 2019.

When you request your health information, you'll have access to the following:

- Claims and "encounter" data[1] concerning your interactions with health care providers; and
- Clinical data we collect in the process of providing case management, care coordination, or other services to you.

Note: The disclosed information may include information about treatment for substance use disorders, mental health treatment, HIV status, or other sensitive information.

[1]"Encounter" data is information about office visits and other interactions with providers that are paid for under a monthly (or annual) fee that Wellmark pays a provider for giving care to members. This type of payment arrangement is referred to as a "capitation arrangement."

Get your health information as a current Wellmark member
☐ By checking this box and entering your signature on this appointment form, you understand as a Wellmark member, you can access your health information any time in your myWellmark® account. You may access this information anywhere by logging in or registering for your account (https://www.wellmark.com/mywellmark) and downloading the app on your smartphone or tablet (https://www.wellmark.com/insurance-explained/more-tools-and-benefits).

If you're requesting health information for someone else
If you're requesting another person's health information as their attorney-in-fact or agent (POA), parent, legal guardian or other form of personal representative, you may need to provide materials to establish your relationship to the member.

I. HOW TO PROTECT YOUR INFORMATION

It is important to understand the App you select will have access to your health information. Reference to "App" in this document includes the entity offering the App. The App is not subject to the HIPAA Privacy Rule (https://www.hhs.gov/hipaa/for-individuals/faq/187/what-does-the-hipaa-privacy-rule-do/index.html) and other privacy laws (https://www.consumer.ftc.gov/articles/0018-understanding-mobile-apps#privacy), which generally protect your health information. Instead, the App's privacy policy describes self-imposed limitations on how the App will use, disclose and possibly sell information about you. An App that publishes a privacy notice is required to comply with the terms of its notice, but generally is not subject to other privacy laws.

If you decide to access your information through the Patient Access API, you should carefully review the privacy policy of any App you are considering using to ensure you are comfortable with what the App will do with your information.

Questions to ask when selecting an App:

- Will this App ***sell*** my data for any reason?
- Will this App ***disclose*** my data to third parties for purposes such as research or advertising?
- How will this App ***use*** my data? For what purposes?
- Will the App allow me to limit how it uses, discloses, or sells my data?
- If I no longer want to use this App, or if I no longer want this App to have access to my health information, can I terminate the App's access to my data? If so, how difficult will it be to terminate access?
- What is the App's policy for ***deleting*** my data once I terminate access? Do I have to do more than just delete the App from my device?
- How will the App inform me of changes to its privacy practices?
- Will the App collect non-health data from my device, such as my location?
- What security measures does this App use to protect my data?
- What impact could sharing my data with this App have on other individuals, such as my family members?
- Will the App permit me to access my data and correct inaccuracies? (Note that correcting inaccuracies in data collected by the App will not affect inaccuracies in the source of the data.)
- Does the App have a process for collecting and responding to user complaints?

If the App's privacy policy does not answer these questions to your satisfaction, you may want to reconsider using the App to access your health information. Your health information may include very sensitive information. You should therefore be careful to choose an App with strong privacy and security standards to protect it.

J. REPORT SUSPICIOUS BEHAVIOR

The Federal Trade Commission Act protects against deceptive acts, such as an App that discloses personal data in violation of its privacy notice. An App that violates the terms of its privacy notice is subject to the jurisdiction of the Federal Trade Commission (FTC). If you believe an App inappropriately used, disclosed, or sold your information, you should contact the FTC. You may file a complaint with the FTC using the FTC complaint assistant (https://www.wellmark.com/i-buy-my-own/medical-plans/know-your-benefits/) with OCR related to HIPAA requirements or file a complaint with Wellmark by contacting Customer Service at the phone number listed on the back of your ID card.

Your signature below confirms that you have read and agreed to the above educational materials.

Signature____ Date _____/_____/_____

Wellmark Language Assistance

Discrimination is against the law

Wellmark Blue Cross and Blue Shield complies with applicable state and federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

Wellmark provides:

- Free aids and services to people with disabilities so they may communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

You have the right to get this information and help in your language for free. If you need these services, call 800-524-9242.

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意： 如果您说普通话， 我们可免费为您提供语言协助服务。 请拨打 800-524-9242 或 （听障专线： 888-781-4262）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية, فإننا نوفر لك خدمات المساعدة اللغوية، المجانية. اتصل بالرقم 800-524-9242 أو (خدمة الهاتف النصي: 888-781-4262).

ສິ່ງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ທີ່. (TTY: 888-781-4262.)

주의: 한국어 를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें : अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, नि:शुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION : si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deitsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

တၢ်ဒုးသ့ၣ်ညါ–နမ့ၢ်ကတိၤကညီကျိာ်,ကျိာ်တၢ်မၤစၢၤတၢ်ဖံးတၢ်မၤတဖၣ်,လၢတဘၣ်လၢ်ဘူးလဲ,အိၣ်လၢနဂီၢ်လီၤ.ဆဲးကျိးဆူ ၈၀၀–၅၂၄–၉၂၄၂မ့တမ့ၢ်(TTY:၈၈၈–၇၈၁–၄၂၆၂)တက့ၢ်.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ । 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस् ।

ማሳሰቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ እገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም (በTTY: 888-781-4262) ይደውለው ያነጋግሩን።

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maaɗa. Heɓir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNAA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) quunnamaa.

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

Ge': Diné k'ehjí yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló̜. Koji̜' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)

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