MCS Classicare (HMO)

AUTHORIZATION FOR USE OF HOME BUNDLE BENEFIT

Indicate who is completing this authorization (check one): ( ) Member ( ) Authorized Representative

I. MEMBER'S INFORMATION

_____ _____

Member's Name (*printed in block letter*) **Date of birth** (*month/day/year*)

Contract number: _____

Address: _____

Telephones: Home: _____ Mobile: _____ Other: _____

II. SCOPE OF AUTHORIZATION

A. I hereby authorize _____ to (*check one only*):
(*name of the authorized representative*)

(*initials*) _____ To request and administer, on behalf and for the sole benefit of the member named herein, the Home Bundle benefit offered by **MCS Classicare (HMO)**. This authorization is limited to the products and/or services included in the plan under the Home Bundle benefit, as applicable and eligible.

(*initials*) _____ To request information regarding the Home Bundle benefit balances only.

B. This authorization will be in effect as long as the member's coverage is active, or until duly revoked.

C. ***If this authorization is made by an authorized representative***: Include with this authorization evidence of the legal capacity of your representation. For example, guardianship, court order, or power of attorney. This authorization will not be deemed valid if proper documentation is not provided.

- The following documents are included: _____

(*initials*) _____ I understand that I have the right to revoke this authorization at any time. I understand that my decision to revoke this authorization must be in writing and sent to **MCS Classicare**. If I refuse to sign this authorization it will not affect the benefits under my coverage. This authorization is only valid to use, receive and/or disclose specific information about the Home Bundle benefit. This authorization is not equivalent to a HIPAA authorized representative authorization. In the event that **MCS Classicare** already has an Authorization to Use and/or Disclose PHI (a "PHI Authorization"), this authorization does not replace or affect such PHI Authorization.

_____ _____

Signature of member or authorized representative **Date** (*month/day/year*)

_____ _____ _____

Name of witness (*if needed*) **Signature** **Date** (*month/day/year*)

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