MCS Classicare (HMO)

REQUEST FOR REVOCATION OF MY AUTHORIZATION TO USE THE HOME BUNDLE BENEFIT

_____

Member or Authorized Representative[1] name (*printed in block letter*)

Contract number: _____

Birth date (*month/day/year*): _____

Address: _____

_____

Phones: Home: _____ Cellular: _____ Other: _____

- **Revocation**: I hereby request revocation of the **AUTHORIZATION TO USE HOME BUNDLE BENEFIT** ("*home bundle*") submitted to MCS Classicare (HMO) to the following person or entity:

  _____

  (*name of the person or entity previously authorized*)

- I understand that this revocation will not affect the benefit on my coverage.
- This revocation is only valid to not use, receive and/or disclose specific information about the home bundle benefit.
- I understand that this document does not constitute a revocation of authorized representative under HIPAA.

_____ _____

Signature of member or authorized representative[1] **Date** (*month/day/year*)

[1] *Authorized representative must include evidence regarding the legal capacity of representing the member (e.g., guardianship, court order, power of attorney, etc.)*

_____ _____ _____

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

