AUTHORIZATION REGARDING PROTECTED HEALTH INFORMATION
(Employer Assistance)

I hereby authorize individuals in my employer's Human Resources/Personnel/Benefits department to obtain Personal Health Information ("PHI") about the individual listed below to assist me with obtaining or understanding coverage or benefits under the group health plan sponsored by my employer.

PHI may be used or disclosed for these purposes with: (**Check all that apply)**

__ Meritain, with respect to eligibility for coverage or payment, denial, pend status or appeals of claims for benefits

__ ICM, with respect to requests for pre-certification or determinations of medical necessity, including appeals

__ ________________________, with respect to __________________________
(insert name of person or company with whom PHI may be discussed or provided, and for what purpose)

PHI may be used or disclosed for this individual:

_______________________ ______________ ___________________________
Name of Covered Person Date of Birth Social Security Number

This authorization will expire one year from the date signed, unless I revoke it in writing before that time. Any revocation should be sent to my employer's Human Resources/Personnel/Benefits Department. I understand that revocation will not affect any action taken before a revocation was received.

I understand that I am **not** required to sign this authorization to be eligible to enroll in the plan or to receive benefits under the group health plan.

___________________________________ _______________________________
Signature of Participant Date

____________________________________ _______________________________
Signature of Patient, if age 18 or older Date

(Employer: Provide a copy of this authorization to the individual who signed it, and keep the original authorization for 6 years from the date signed.)