DEAN HEALTH PLAN, INC. (AS THE INSURER OFFERING PREVEA360 HEALTH PLAN)

AUTHORIZATION FORM
To Permit Use and Disclosure of Protected Health Information

PURPOSE OF THIS FORM: This Authorization Form is to be used when an individual wishes to give another person access to his/her health information. When completed, it will allow Dean Health Plan to disclose your health information to the person(s) stated on this form.

SECTION A: Individual Authorizing Use and/or Disclosure

Name of Member | Subscriber Number | Date of Birth

Street Address | Telephone

City, State, Zip Code

SECTION B: The Use and or Disclosures Being Authorized

I hereby authorize the following disclosure of my protected health information as indicated below by Dean Health Plan, 1277 Deming Way, Madison, WI 53717.

☐ Case Management Records ☐ Claims Correspondence ☐ Claims Payment Summary
☐ Enrollment Records ☐ Other (Specify) _____

For the following date(s) _____

Specific purpose of the use or disclosure: (check applicable categories)

☐ Coordination of benefits ☐ Payment of claim(s) ☐ Prior authorization
☐ Grievance ☐ Insurance eligibility/benefits ☐ Other _____

To disclose protected health information to: _____
Name of Individual/Organization

_____
Street Address

_____
City, State, Zip Code

SECTION C: Individual's Signature

Right to Refuse to Sign This Authorization – I understand that I am under no obligation to sign this form and that Dean Health Plan may not condition treatment, payment, or eligibility for health care benefits on my decision to sign this authorization.

Right to Withdraw This Authorization - I understand written notification is necessary to revoke this authorization. To obtain information on how to revoke my authorization, I may contact Customer Service at 877-230-7555. I am aware that my revocation will not be effective until received by Dean Health Plan and that it will not have any effect on disclosures made prior to receipt of my revocation

Redisclosure Notice - I understand once that Dean Health Plan discloses my information based on this authorization, this information may no longer be protected by federal and state privacy standards and that my health information may be redisclosed without obtaining my authorization.

Expiration - This authorization will expire 30 months from the date signed, unless I specify another date or event here:_____
_____

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization form, I am confirming that it accurately reflects my wishes. I am entitled to keep a copy of this form for my records.

Signature of You or Your Personal Representative: _____

Please Print Name: _____ Date: _____

If signed by a Personal Representative, please attach appropriate documentation verifying legal authority, such as Guardianship or Power of Attorney Documents.