PAYFLEX®

Authorization to Release Personal Information

Fax Completed Form to: 1-402-978-3728
You may also mail a completed form to:
PayFlex Systems USA, Inc.
PO Box 981158
El Paso, TX 79998-1158

YOU SHOULD READ THIS CAREFULLY. When you complete and sign this form, you give PayFlex Systems USA, Inc. (PayFlex) permission to release your personal information to another person or organization*. You'll name the Authorized Representative below. Your personal information pertains to your account at PayFlex. It may include, but is not limited to: Claim information (provider name; if you need to substantiate a claim; amount; etc.); reimbursements that the account has paid; explanation of payment (EOP); receipt request letters; premiums that you pay; insurance carrier name; web access status; debit card status; bank account information; and general plan inquiries.

The federal privacy standards that protect your personal information may not apply to your Authorized Representative. This means your Authorized Representative may be able to give your information to others.

This authorization ends twelve months after the date your benefit eligibility terminates, as reported by your Plan. But you can end this authorization earlier. You can use this form to notify us in writing. This is important because we can't cancel an authorization over the phone. If you do cancel early, it won't affect any actions taken before we receive your written request.

This request is voluntary. It has no impact on your eligibility for benefits; treatment you receive; your enrollment; or claim payments. Your plan can't ask you to sign this form for any reason.

*Don't use this form to allow your providers to file billing, claim or Explanation of Benefits (EOB) information or documentation. They don't need your signed authorization to submit that information to PayFlex.

Instructions

1. To authorize the release of personal information, complete sections A, B, C and E of this form. Return it to PayFlex.
2. To revoke or cancel an authorization, complete sections A, B and D of this form. Return it to PayFlex.

Note: We can't process this form if it isn't completed and signed. We may also need additional documentation to process this form.

Section A – Member Information (This is the person whose information will be released.)

AUTHORIZED REPRESENTATIVE WILL NEED TO HAVE ALL OF THIS INFORMATION WHEN CONTACTING PAYFLEX.

Member Name *(First, MI, Last)*	**Member Number** OR **Social Security Number** *(Last four digits only)* XXX-XX-		
Address	**City**	**State**	**ZIP Code**
Employer Name *(Previous employer if COBRA or Retiree Account)*	**Daytime Telephone** ( ) -		

Section B - Authorized Representative Information (This is the person or organization that you authorize to receive Member information.)

MEMBER MUST COMPLETE A SEPARATE FORM FOR EACH AUTHORIZED REPRESENTATIVE.

Authorized Representative or Organization Name

In most cases, no additional documents must be submitted with this form. Just be sure the Member signs it. This is needed in order for the authorization to become effective. There are two situations where additional documents are needed:

1. If the Member is deceased: You must send PayFlex executorship or similar documentation and the death certificate. PayFlex can't discuss the deceased member's account with anyone without this documentation. PayFlex can't rely on a Durable Power of Attorney, Advance Directive, Guardianship or Conservatorship papers after the death of the Member. Those powers are no longer valid.
2. If the Member is incapacitated: If the member's Legal Representative signed this form, then they must send PayFlex documentation that verifies the Legal Representative's status. Legal documentation includes a Durable Power of Attorney, Guardianship or Conservatorship papers.

Section C - Information To Be Released To Authorized Representative (Select only one.)

☐ **Grant Full Account Access** – This gives the Authorized Representative the same access as the Member. It allows the Authorized Representative to receive all account information; submit claims and required documents; and make changes to the account. This includes resetting web login and password; requesting debit cards and changing account information.

☐ **Grant Limited Account Access** – This is for information available by phone only. It won't allow the Authorized Representative to make or authorize account changes. And it won't allow the Authorized Representative to request or receive any member specific account documents.

Section D - Revocation / Cancellation Request

Complete only when requesting PayFlex to revoke or cancel an authorization request. You must complete Sections A, B and D.
Until PayFlex receives and processes your request to cancel, the Authorized Representative still has the access that you previously granted.

I wish to revoke/cancel account access for (Authorized Representative Name)		
Member Name	**Signature**	**Date**

Section E – Member Signature or Legal Representative's Signature

I request and authorize PayFlex to release my information to the Authorized Representative named above. I understand that this may include protected health information (PHI). I understand that this authorization expires at the end of the twelve-month period following the end of my coverage. I also understand that this authorization will be in place until then, unless I send a written request to cancel it. I understand this request is voluntary for me. The plan cannot base my eligibility for benefits, treatment, enrollment or claims payment on this authorization. I also understand that once information is disclosed to the Authorized Representative, the federal privacy standards protecting my health information may not apply to the Authorized Representative. I understand that this means that the Authorized Representative may be able to share this information.

Print Name	**Signature** (If member signs, no additional documents are needed.)	**Date**

Keep a copy of this completed form for your personal records