Personal Representative Authorization Form

About this form
You may submit this Personal Representative Authorization (PRA) if you would like to designate a Personal Representative to act on your behalf. If a Personal Representative signed your application for you, or if you are a Personal Representative applying on behalf of someone else, you **must** submit this form for the application to be processed.

Note: A Personal Representative designated through this form has the authority to act on an applicant's or member's behalf in all matters with Fallon Health, and will receive personal information about the applicant or member *until we receive a cancellation notice terminating their authority*. Their authority will *not* automatically terminate once we process your application.

If you would like, you can choose someone to help you.

You may choose a Personal Representative to help you get health care coverage through programs offered by Fallon Health by completing this form. However, you are not required to have a representative in order to apply for or receive benefits.

Who can help me?

1. A Personal Representative can be a friend, family member, relative, or other person or organization of your choosing who agrees to help you. It is up to you to choose a Personal Representative if you want one. Fallon Health will NOT choose a Personal Representative for you. To select a Personal Representative:
    a. You must designate the person or organization in writing, by filling out Section I, Part A of this form, who you want to be your Personal Representative.
    b. Your Personal Representative must also fill out Section I, Part B.

    You must fill out a separate PRA form if you want to name more than one person or organization to serve as your Personal Representative.

2. A person appointed by law to act on behalf of the estate of an applicant or member who has died can also serve as a Personal Representative by following the instructions above. This type of Personal Representative may be a legal guardian authorized to make medical decisions, holder of a durable power of attorney, or health care proxy, or, if the applicant or member has died, the estate's administrator or executor. What this person is authorized to do for you or for the applicant or member's estate will depend on the wording of the legal appointment. This person completes information in Section II of this form and is referred to as a **Section II** Personal Representative.

What can a Personal Representative do?

A Personal Representative may:

- Fill out your application or eligibility review forms;
- Fill out other Fallon Health eligibility or enrollment forms;

- Give proof of information reported on these forms;
- Report changes in income, address, or other circumstances;
- Get copies of all of your Fallon Health eligibility and enrollment notices; and
- Act on your behalf in all other matters with Fallon Health including filing an appeal, a grievance or a request for service.

How does a Personal Representative designation end?

If you decide that you no longer want a Personal Representative, you must notify us at the time you want the designation to end by mailing a letter notifying us that the designation has ended to:

Fallon Health
Privacy Coordinator
10 Chestnut St.
Worcester, MA 01608
or
Fax: 1-508-831-1136

The notice must include:

- Your name
- Your address
- Your date of birth
- The name of your Personal Representative
- A statement that the designation has ended
- Your signature or the signature of someone acting on your behalf (in the case of a **Section II** Personal Representative only).

In addition, if your Personal Representative notifies us that they are no longer acting on your behalf, we will no longer recognize that person or organization as your Personal Representative.

A **Section II** Personal Representative's designation ends when his or her legal appointment ends. The Personal Representative must notify us as instructed above.

How do I submit this form?

You must send the PRA form to the following:

Fallon Health
Privacy Coordinator
10 Chestnut St.
Worcester, MA 01608
or
Fax: 1-508-831-1136

Personal Representative Authorization Form

Section I – Member, Applicant and Personal Representative Information.

Part A—to be filled out by applicant or member. Please print, except for signature.

Member/Applicant information:

First name:	Middle initial:	Last name:	
Street address:	City:	State:	ZIP code:
Date of birth:	Telephone:	Fallon member ID number:	

I certify that I have chosen the following person or organization to be the Personal Representative for myself and that I understand the duties and responsibilities this person or organization will have (as explained earlier in this form).

Signature of member or applicant Date

Personal Representative Information:

First name:	Middle initial:	Last name:	
Name of organization *(if applicable):*			
Street address:	City:	State:	ZIP code:
Telephone:	Email address:		

Part B—to be filled out by the Personal Representative. Please print, except for signature.

B1. Complete if Personal Representative is an individual

I hereby accept the above appointment. I certify that I have not been disqualified, suspended or prohibited from practice before the United States Department of Health and Human Services. I am not a current or former employee of the United States disqualified from acting as a representative of a beneficiary under a federal government program. I recognize that any fee may be subject to review and approval by the Secretary of the Department of Health and Human Services.

I certify that I will at all times maintain the confidentiality of any information regarding the applicant or member set forth above that is provided to me by Fallon Health.

If I am also a provider, staff member, or volunteer affiliated with an organization, and I am acting in my own capacity, and not on behalf of any organization, in connection with my designation as a Personal Representative, I certify that I will at all times adhere to all applicable state and federal laws and regulations regarding confidentiality of information and conflicts of interest including those set forth at 201 CMR 17.00, 42 C.F.R. part 431, subpart F, 42 C.F.R. § 447.10, 45 C.F.R. § 155.260(f) and 45 CFR Part 164.

Signature of Personal Representative Date

Personal Representative's printed name:	Email Address:

B2. Complete if Personal Representative is an organization.
I hereby accept the above appointment on behalf of the organization set forth below. I certify that I have not been disqualified, suspended or prohibited from practice before the Department of Health and Human Services; I am not, as a current or former employee of the United States, disqualified from acting as a representative of a beneficiary under a federal government program. I recognize that any fee may be subject to review and approval by the Secretary.

I certify, on behalf of the organization set forth below, that such organization will at all times maintain the confidentiality of any information regarding the applicant or member set forth above that is provided to the organization by Fallon Health.

I, the provider, staff member, or volunteer of the organization set forth below, completing this form, certify on behalf of myself and on behalf of the organization I represent, that any providers, staff members, or volunteers acting on behalf of the organization in connection with this Personal Representative designation will at all times adhere to all applicable state and federal laws and regulations regarding confidentiality of information, and conflicts of interest, including those set forth at 201 CMR 17.00, 42 C.F.R. part 431, subpart F, 42 C.F.R. § 447.10, and 45 C.F.R. § 155.260(f) and 45 CFR Part 164.

Signature of provider, staff member, or volunteer completing form	Date

Printed name of provider, staff member, or volunteer completing form:	Email address:
Personal Representative organization name:	

Section II. Signature if person filling out this form is someone other than the member or applicant.

Printed name of person filling out this form:

First name:	Middle initial:	Last name:	
Street address:	City:	State:	ZIP code:
Telephone:	Email address:		

Signature of person filling out the form	Date

Authority of person filling out this form to act on behalf of the applicant or member:*

☐ Health Care Proxy ☐ Guardian authorized to make health care decisions
☐ Holder of a durable power of attorney

*If this form is being filled out by someone who has been appointed by a court as a legal guardian, or who is a holder of a durable power of attorney or health care proxy, a copy of the applicable legal document must be attached.

Waiver of Payment for Items or Services at Issue

To be completed by the Personal Representative only if the representative is a provider or supplier and the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, and could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature of Personal Representative	Date

Personal Representative's printed name	Email address

Charging of fees for representing beneficiaries before the Secretary of the Department of Health and Human Services (DHHS)

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of the Department of Health and Human Services (DHHS) (i.e., the Administrative Law Judge (ALJ) hearing, Medicare appeals Council (MAC) review, or a proceeding before an ALJ or the MAC as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR §405.910(f).

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing or request for MAC review.

Approval of a representative's fee is not required if (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court-appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. Section III of this document can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation.

Authorization of fee

The requirement for the approval of fees ensures that the representative will receive fair value for the services performed before DHHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, the ALJ or MAC considers the nature and type of services performed, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

Conflict of interest

Sections 203, 205, and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.

Where to send this form

Send this form to:

Fallon Health
Privacy Coordinator
10 Chestnut St.
Worcester, MA 01608
or
Fax: 1-508-831-1136

If additional help is needed, please call the phone number on the back of your member ID card or 1-800-MEDICARE (1-800-633-4227).

NaviCare is a voluntary program in association with MassHealth/EOHHS and CMS.

SCO_2018_70 Approved 12052017
SE AH37_17
17-735-018 Rev.00 10/17