AUTHORIZATION FOR DISCLOSURE OF HEALTH-RELATED INFORMATION

(This authorization complies with HIPAA Privacy Rules.)

Name of Policyholder:	**Policy Number:**
Address Line 1:	**Address Line 2:**
City, ST, Zip:	**Date of Birth: ____/ _____/ _____**

NOTE: If this form is being completed by a Legal Representative then a valid Power of Attorney, Guardianship, Conservatorship, or similar documentation must accompany this form.

Health Information to be Disclosed *by* Senior Health Insurance Company of Pennsylvania I authorize the Company to disclose my Protected Health Information to the following

(Person/Organization Receiving Information): ___Financial Health Services, LLC_____

_____

The Relationship of this person/organization to me is: ___Provider_____

This recipient may use the health information authorized on this form for the following purpose(s):
__To assist with the claims process throughout the duration of the claim_____

_____

This authorization shall be effective as of the date of my signature below. I understand that I can revoke this authorization at any time, except to the extent it has already been relied upon, by giving written notice to: **Senior Health Insurance Company of Pennsylvania**, *Attn: Claim Review,* ***P. O. Box 64913, MN 55164***. I understand that the Company may not deny me benefits due to refusal to sign this authorization. I further understand that my signature on this form does not authorize any changes to my policy information or to my policy or change the way the Company communicates with me. I also understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient. The undersigned is entitled to receive a copy of this form. A photocopy of this authorization shall be as valid as the original.

Policyholder (or Legal Representative)

Signature: X_____ Date: _____

Type of authority to act or sign on behalf of the policyholder (please check box, if applicable):

☐ Legal Representative ☐ Power of Attorney ☐ Guardianship ☐ Conservatorship

SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA
P.O. Box 64913 • St. Paul, MN 55164
Telephone: 1-877-450-5824

Direction to Pay

Claimant Name: _____ Policy Number: _____

This Direction to Pay revokes any previous assignments authorized by _____, the Claimant or the guardian of the Claimant (legal documentation of guardianship or other representative capacity, if appropriate, is attached), and hereby authorizes direct payment to _____, the service provider, for any Long-Term Care benefits otherwise payable to or on behalf of the Claimant for covered services at a rate not to exceed the Provider's regular charges. It is understood that this Direction to Pay does not transfer any rights under the policy of insurance. It is agreed that payment to the Provider, pursuant to this Direction to Pay, by the plan administrator shall discharge this long term care insurer of any and all obligation under the plan to the extent of such payments. It is understood by the undersigned that he/she is financially responsible for any charges not covered by this Direction to Pay.

_____
Service Provider Representative Signature

_____
Printed Name of Service Provider Representative

_____
Date

_____
Claimant/Legal Representative Signature

_____
Printed Name of Claimant/Legal Representative

_____
Date

☐ Financial Power of Attorney is attached if signed by a Legal Representative

Name of Service Provider: ____Financial Health Services LLC_____

Address of Service Provider:_325 Sentry Pkwy, Bldg 5 East, Ste 160 City: Blue Bell____ State: PA Zip: 19422

Provider's Federal Tax ID Number: ___ _____ _____

A completed W-9 form verifying the provider's Federal Tax ID Number is required for benefit assignment.