PLEASE READ THE INSTRUCTIONS CAREFULLY AND COMPLETE THE FORM BELOW. INCOMPLETE FORMS CANNOT BE ACCEPTED.

For assistance with this form please see the Notice on page 2 or call Member Services at the number listed below. Hours are from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.

wellcare PRIME by absolute total care | Healthy Connections PRIME	**Wellcare Prime by Absolute Total Care (Medicare-Medicaid Plan)**	**1-855-735-4398 (TTY: 711)**

1 MEMBER INFORMATION:

Member Name *(print)*: _____

Address: _____

City:_____ State: _____ Zip:_____ Phone: (_____) _____ - _____

Member Date of Birth: _____ Member ID Number:_____

2 I GIVE WELLCARE PRIME PERMISSION TO USE MY HEALTH INFORMATION FOR THE PURPOSE IDENTIFIED OR TO SHARE MY HEALTH INFORMATION WITH THE PERSON OR GROUP NAMED BELOW. THE PURPOSE OF THE AUTHORIZATION IS *(check one option below)***:**

□ to allow Wellcare Prime to help me with my benefits and services OR

□ to permit Wellcare Prime to use or share my health information for _____

3 PERSON OR GROUP TO RECEIVE INFORMATION (one form per person or group):

Name (person or group): _____

Address: _____

City:_____ State: _____ Zip:_____ Phone: (_____) _____ - _____

4 I AUTHORIZE WELLCARE PRIME TO USE OR SHARE THE FOLLOWING HEALTH INFORMATION *(NOTE: Select the first statement to release **ALL** health information or select the second statement to release only **SOME** health information.)*

Check only one box below. Both CANNOT be selected.

□ **All of my health information INCLUDING:**
Genetic information, services, or test results; HIV/AIDS data and records; mental health data and records (but not psychotherapy notes); prescription drug/medication data and records; and drug and alcohol data and records (please specify any substance use disorder information that may be disclosed).

OR

□ **All of my health information EXCEPT** *(check only the boxes below that apply)***:**
- □ Genetic information, services, or tests
- □ AIDS or HIV data and records
- □ Drug and alcohol data and records
- □ Mental health data and records (but not psychotherapy notes)
- □ Prescription drug/medication data and records
- □ Other:_____

5 THIS AUTHORIZATION ENDS ON THIS DATE/EVENT: _____

Date this authorization ends unless cancelled. If this field is blank, the authorization expires one year from the date of the signature below.

6 MEMBER OR LEGAL REPRESENTATIVE SIGNATURE: _____

DATE: _____

IF LEGAL REPRESENTATIVE - Relationship to Member: _____

If you are the Member's legal or personal representative, you must send us copies of relevant forms, such as power of attorney or order of guardianship.

MAIL COMPLETED AUTHORIZATION FORM AND ANY SUPPORTING DOCUMENTATION TO

Wellcare Prime by Absolute Total Care, ATTN: Compliance Department

100 Center Point Circle, Suite 100, Columbia, SC 29210

Authorization to Use and Disclose Health Information

Notice to Member:

- Fill in all the information on the form. When finished, mail the form and any supporting documentation to:

Wellcare Prime by Absolute Total Care (Medicare-Medicaid Plan)
ATTN: Compliance Department
100 Center Point Circle, Suite 100
Columbia, SC 29210

For assistance with this form please call Member Services at the number listed below.

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- Completing this form will allow Wellcare Prime to (i) use your health information for a particular purpose, and/or (ii) share your health information with the individual or entity that you identify on this form.
- You do not have to give permission to use or share your health information. Your treatment, payment, enrollment, or eligibility for services with Wellcare Prime will not change if you do not submit this form. If you want to cancel this authorization form, send us a written request to revoke it at the address on the bottom of this page. A revocation form can be provided to you by calling Member Services for your plan at the number listed above or on the back of your member ID card.
- If you want to cancel this authorization form, except in situations where:(a) the Company has taken action in reliance thereon; (b) the authorization was obtained as a condition of obtaining insurance coverage and other law provides the insurer with the right to contest a claim under the policy or the policy itself, send us a written request to revoke it at the address on the bottom of this page. A revocation form can be provided to you by calling Member Services for your plan at the phone number listed above or on the back of your member ID card.
- Wellcare Prime cannot promise that the person or group you allow us to share your health information with will not share it with someone else and no longer be protected by 45 C.F.R. Part 164.
- If you are consenting to disclose any substance use disorder records to a recipient that is neither a third party payor nor a health care provider, facility, or program where you receive services from a treating provider, such as a health insurance exchange or a research institution (hereafter, “recipient entity”), you must specify the name of an individual with whom or the entity at which you receive services from a treating provider at that recipient entity, or simply state that your substance use disorder records may be disclosed to your current and future treating providers at that recipient entity.
- Keep a copy of all completed forms that you send to us. We can send you copies if you need them. You can request these by calling Member Services for your plan at the phone number which can be found above or on the back of your member ID card.
- If you need help, contact Member Services at the phone number listed above or on the back of your member ID card.

Wellcare Prime by Absolute Total Care (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and South Carolina Healthy Connections Medicaid to provide benefits of both programs to enrollees.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-735-4398 (TTY: 711) de 8 a.m. a 8 p.m., de lunes a viernes. Luego del horario de atención, los fines de semana y los días feriados federales, es posible que se le pida que deje un mensaje. Le devolveremos la llamada el próximo día hábil. La llamada es gratuita.