

SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA

**AUTHORIZATION FOR CLAIM PROCESSING PURPOSES Pursuant to the HIPAA Privacy Rule
§164.508(c)**

I, the undersigned, authorize any licensed physician, medical practitioner, hospital, clinic, medical or medical related facility, the Veteran's Administration, insurance company, the Medical Information Bureau, Inc. (MIB), employer or Government agency to disclose personal information about me as described below.

This authorization was prepared by Senior Health Insurance Company of Pennsylvania for purposes of obtaining personal information necessary to process a claim for benefits. The information subject to this authorization is any and all information, including health information, requested by Senior Health Insurance Company of Pennsylvania for the purpose stated above as well as any information provided to them or their affiliated insurance companies on any previous applications. The information covered by this authorization does not include psychotherapy notes but does include any information about drug abuse, alcoholism, and mental illness. In addition, the information covered by this authorization does include any such information that has been restricted by my request.

Persons or entities employed by or authorized by Senior Health Insurance Company of Pennsylvania to perform tasks related to the claims process are hereby authorized to use the personal information covered by this authorization. I understand that if the person or entity that receives this information is not a health care provider or health plan covered by federal privacy regulations, the information will likely no longer be protected by the federal privacy regulations and may be subject to redisclosure. However, I further understand that all such persons or entities have signed agreements to protect said information.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Senior Health Insurance Company of Pennsylvania, or, so long as Senior Health Insurance Company of Pennsylvania has a legal right to contest the coverage or a claim under the coverage. Revocation requests must be sent in writing to:

Senior Health Insurance Company of Pennsylvania
P.O. Box 64913 St. Paul, MN 55164

I understand that Senior Health Insurance Company of Pennsylvania cannot condition the payment of a claim on my signing this authorization. This authorization will expire upon the final action related to the claim for which this authorization is signed.

A copy of this authorization may be used in place of the original. If this authorization is for someone other than myself, that individual and my authority to act on his/her behalf are explained below.

(Please Print) Name of Individual Whose Information is Covered By This Authorization

Signature of Individual and Date

(Please Print) Name of Representative with authority to act on behalf of the Individual Whose Information Is Covered By This Authorization

Relationship of Representative to Individual

Signature of Representative and Date