



# DESIGNATED PERSONAL REPRESENTATIVE FORM

## Important Information

As a parent, guardian, or other legally authorized (approved) personal representative, you have the right to access certain medical information about the individual you are authorized to represent. You will need to submit (send) documentation proving your authority to represent the individual. Complete this form and send it with valid documentation to:

Partnership HealthPlan of California  
Attn: Member Services – Northern Region  
3688 Avtech Pkwy  
Redding, CA 96002  
(530) 223-2508

**OR**

Partnership HealthPlan of California  
Attn: Member Services – Southern Region  
4665 Business Center Drive  
Fairfield, CA 94534  
Fax: (707) 420-7580

These are **examples** of the types of documentation you will need to submit:

**Custodial/Non-Custodial Parent** – Please submit one of the following:

- Custody and Visitation (Parenting Time) Order Attachment (form FL-341)
- Findings and Order After Hearing (form FL-340)
- Judgment (form FL-180 or form FL-250)
- Stipulation and Order for Custody and/or Visitation of Children (Form FL-355)

**Guardianship/Adoption** – Please submit one of the following:

- Order Appointing Guardian of Minor
- Adoption Order (ADOPT-215)
- Birth Certificate identifying Adoptive Parent(s)

**Conservatorship** – Please submit:

- Order Appointing Conservator

**Administer of Estate/ Executor of Will** – Please submit:

- Order for Probate (form DE-140) and Letters (form DE-150)

**Foster Parent/Foster Care Agency/Public Health Nurse** – Please submit:

- Foster Parent Agreement or Placement Agreement and Release of Information signed by State Agency.

**Medical Power of Attorney:**

- Please make sure the document you submit authorizes you to make health care decisions. A statement from Member's primary physician may be required.

### Member Information

First Name:	Last Name:
Address:	
Phone Number: (     )	Date of Birth:
Member ID/CIN:	

### Personal Representative Information

First Name:	Last Name:
Address:	
Phone Number: (     )	Date of Birth:

### Authorization Expiration

<input type="checkbox"/> This Authorization will expire in exactly one year or on (a date is required): _____
<input type="checkbox"/> Date of next Court hearing: _____

### Documentation of Legal Authority Submitted

Please check the box next to the type of legal authority of the Personal Representative.

<input type="checkbox"/> Parent of Minor/Custodial Parent	<input type="checkbox"/> Parent of Minor/Non-Custodial Parent
<input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Adoptive Parent
<input type="checkbox"/> Conservator	<input type="checkbox"/> Medical Power of Attorney
<input type="checkbox"/> Administer of Estate/Executor of Will	<input type="checkbox"/> Foster Parent/Foster Care Agency
<input type="checkbox"/> Other:	

### Certification of Personal Representative

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

_____	_____
Signature	City, State
_____	_____
Print Name	Date

### Verification of Documentation (For PHC Use Only)

Copy of Documentation Attached?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Type of Documentation Attached:		
Verified by PHC Staff:	Name:	
	Dept.:	