PCIP
Pre-Existing Condition Insurance Plan
*Administered by GEHA*

NATIONAL FINANCE CENTER
U. S. DEPARTMENT OF AGRICULTURE

# PCIP Authorization to Share Personal Health Information

Use this form if you want the Federally-run PCIP to share your personal health information with other people or organizations who call PCIP on your behalf. The Federally-run PCIP is operated by the U.S. Department of Agriculture's National Finance Center, other Federal agencies, and the PCIP benefits administrator.

## 1. Your information.

Print Name (first & last name of PCIP applicant/enrollee)

| PCIP Account Number or PCIP ID Number (if known) | Date of Birth (mm/dd/yyyy) |
|---|---|
| | |

## 2. PCIP will only share the personal health information you agree to.

2A: Check **one** box below to tell us the specific information you agree to share:

- ☐ Limited Information (go to question 2B)
- ☐ Any Personal Health Information that PCIP has about me (go to question 3)

2B: If you selected "Limited Information," check which types of information you agree to share:

- ☐ Information about your PCIP eligibility
- ☐ Information about your PCIP claims
- ☐ Information about your PCIP enrollment
- ☐ Information about premium payments
- ☐ Other specific information (please write below; for example, "payment information")

## 3. Check one box below to let PCIP know how long you agree to share your personal health information.

(Subject to applicable law—for example, your State may limit how long PCIP can share your personal health information.)

- ☐ Share my personal health information two years following my disenrollment from PCIP.
- ☐ Share my personal health information for a limited period only:

beginning: _____ (mm/dd/yyyy) and ending: _____ (mm/dd/yyyy)

## 4. List the names and addresses of the people or organizations you want PCIP to share your personal health information with.

Please provide the specific name of the person for any organization you list:

| 1. Name | Relationship or Organization |
|---|---|
| Address | |

| 2. Name | Relationship or Organization |
|---|---|
| Address | |

| 3. Name | Relationship or Organization |
|---|---|
| Address | |

## 5. I give PCIP permission to share my personal health information listed on page 1 with the person(s) or organization(s) named above.

I understand that my personal health information may be re-disclosed by the person(s) or organization(s) and may no longer be protected by law.

| Signature | Phone Number | Date (mm/dd/yyyy) |
|---|---|---|
| PCIP Applicant/Enrollee Address (Street, City, State & ZIP) | | |

**Are you completing this form for someone else?**

Check here if you're signing as a personal representative, and complete below. Unless you're the parent of a minor child, please attach documented proof that you're acting on that person's behalf (for example, Power of Attorney).

| Address of Person Completing Form (Street, City, State & ZIP) | |
|---|---|
| Phone Number | Relationship to Applicant/Enrollee |

## 6. Send this ORIGINAL completed, signed form to:

**PCIP**
**Attn: Compliance Dept.**
**P.O. Box 438**
**Independence, MO 64051-0438**

## 7. NOTE: You Can Stop Information-Sharing at Any Time

You have the right to stop sharing your personal information at any time, although this won't affect any information that PCIP has already shared. To end your permission, send a written request to the address shown above.

PCIP won't base your treatment, payment, enrollment, or benefit eligibility on whether or not you sign this form.

## Privacy Act and Paperwork Reduction Notice

Section 1101 of the Patient Protection and Affordable Care Act, Public Law 111-148, authorizes us to collect the information on this form. The information you provide will allow the United States Department of Health and Human Services through the United States Department of Agriculture's National Finance Center, other Federal agencies, and the PCIP benefits administrator, Government Employees Health Association, to disclose information, with respect to the status of an application, enrollment, premium billing or claim, to individuals or organizations of your choosing. If you don't provide this information, we won't be able to disclose information about your application, enrollment, premium billing or claim without your prior authorization.

Paperwork Reduction Act Statement. This information collection meets the requirements of 44 United States Code §3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. The valid OMB control number for this information collection is 0938-1161. We estimate that it will take about fifteen minutes to read the form, gather the facts, and answer the questions.

You may send comments on our time estimate to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Send only comments relating to our time estimate to this address, not your form.