DESIGNATED REPRESENTATIVE AUTHORIZATION

MedAssist® a Firstsource company

SECTION I. TO BE COMPLETED BY THE PATIENT OR APPLICANT:

_____	___/___/___	(___)_____	(___)_____
Applicant Name	*Date of Birth*	*Telephone Number*	*Alt Telephone Number*

_____	_____
Address	*City, State, Zip*

I, _____, ("Applicant") appoint Firstsource Solutions USA, LLC dba MedAssist and its employees ("MedAssist") to act as my Designated Representative for the purpose of pursuing financial assistance for my medical expenses and additional programs, government, hospital or otherwise, for which I may be eligible. As my Designated Representative, MedAssist is authorized to act responsibly on my behalf to accompany, assist, and represent me in my application for or redetermination of benefits with any agency or entity that offers such support ("Agency" or "Agencies"). Agency or Agencies may include, but are not limited to, local, state, and federal funding sources such as hospital charity, county human services, Medicaid, and Social Security Administration. I understand that MedAssist receives payment from my healthcare provider, such as a hospital where I received treatment, to provide these financial assistance services on my behalf. I understand that I may change my mind and/or withdraw from applying to financial assistance programs at any time. I will provide MedAssist with my most current contact information so that MedAssist can keep me informed and engaged during the application process and any subsequent related matters.

SECTION II. THIS AUTHORIZATION/POWER OF ATTORNEY ENABLES MEDASSIST TO:

- Obtain information about my assets, employment status, income, tax status and medical condition to substantiate my application(s) and sign authorization forms on my behalf to obtain this information from my bank, credit union, employer and/or government or financial entities;
- Obtain bank statements from my bank, credit union or financial institution.
- Obtain personal property tax records and supporting information from applicable county and/or state agencies.
- Create, access, and use an online account(s) on my behalf and submit application(s) to the applicable hospital client, Agencies for determination of benefits, electronic or otherwise.
- Submit information about me with respect to my assets, employment status, income and medical condition to substantiate my application(s) electronic or otherwise and sign an application with Agencies on my behalf;
- Receive copies of any notices or other communications between Agencies and myself;
- Accompany me to any required face-to-face interview(s) or attend face-to-face interview(s) on my behalf when Agencies allow;
- Pursue the appeal process, up to and including legal proceedings, in the event my application(s) is denied, if MedAssist reasonably determines to be appropriate in my case;
- Create and submit a renewal form;
- Participate on my behalf and in my absence in any hearing or appeal with Agencies;
- Contact Agencies regarding the status of my application(s);
- Act on my behalf in all other matters with Agency/Agencies related to my application(s) and their approval and processing.

SECTION III. I UNDERSTAND AND AGREE THAT:

- This form constitutes a request to exercise my right to access Protected Health Information ("PHI") about me that is maintained by the Agency in a designated record set, including, if applicable information on the status of my application. I have the right to request access to my PHI under the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA").
- Pursuant to 45 C.F.R. §164.524(c)(3)(ii) of HIPAA, I hereby direct the Agency to provide access to my PHI held by the Agency to MedAssist at _____, by phone as requested by MedAssist or hipaa@na.firstsource.com.
- My request for my PHI to be sent to MedAssist expires upon termination or revocation of this Authorization.

SECTION IV. I UNDERSTAND THAT I HAVE THE RESPONSIBILITY TO:

- Be truthful and complete in all statements to MedAssist and appropriate entities to the best of my knowledge;
- Revoke this authorization by either modifying the authorization or by giving the Agency/Agencies signed notice that MedAssist is no longer authorized to act on my behalf;
- Upon revocation, notify MedAssist in writing that this authorization has been revoked. I understand that my revocation will be effective except to the extent that MedAssist has already acted based on this authorization. To inform MedAssist of my revocation of this authorization, I will send my notification in writing to hipaa@na.firstsource.com.

SECTION V. I AGREE AND UNDERSTAND:

- I have had ample time to review all provisions of this authorization/power of attorney;
- Additional forms may be needed to be signed by me in order to process my application(s);
- MedAssist may contact me by telephone at any telephone number associated with me, including wireless telephone numbers or other numbers that result in charges to me, whether provided by me in the past, present or future. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automated dialing device and/or predictive dialing.
- Any information obtained by MedAssist acting as my Designated Representative may be shared with my healthcare provider and/or legal representative, subject to Section VI below.

SECTION VI. EXPLANATION OF CONFIDENTIALITY PROTECTIONS:

As the Designated Representative, MedAssist agrees to maintain the confidentiality of any information regarding the Applicant provided by Agencies to MedAssist, including but not limited to the following:

- Individually Identifiable Health Information, which is information that identifies the Applicant and that relates to the Applicant's past, present or future physical or mental health or condition; the provision of health care to the Applicant; or the past, present, or future payment for the provision of health care to the Applicant. Individually Identifiable Health Information includes demographic information, medical history, test and laboratory results, and insurance information, as well as many common identifiers (e.g., name, address, birth date, Social Security Number).
- Financial information, including the nature of the Applicant's income, assets, liabilities, tax liability, tax payments, potential or actual investigations or litigation related to Applicant's tax return status, written determinations about the Applicant's tax status, and related agreements between the Secretary of the Treasury and the Applicant.

SECTION VII: THE RIGHTS, POWERS AND AUTHORITY OF MY DESIGNATED REPRESENTATIVE COMMENCE ON THE DATE THE AUTHORIZATION IS SIGNED AND SHALL REMAIN IN EFFECT UNTIL THE FINAL CONCLUSION OF MY APPLICATION(S) INCLUDING ANY RE-APPLICATION OR APPEAL IF THE ORIGINAL APPLICATION WAS DENIED OR WHEN REVOKED BY ME OR BY AN INDIVIDUAL AUTHORIZED BY LAW TO ACT ON MY BEHALF.

I ACKNOWLEDGE AND AGREE THAT I HAVE ASKED MEDASSIST TO CREATE, ACCESS AND USE AN ONLINE ACCOUNT(S) ON MY BEHALF AND SUBMIT APPLICATION(S) TO THE APPLICABLE AGENCIES FOR FINANCIAL ASSISTANCE WITH MY MEDICAL BILLS AND I AM ENCOURAGED TO SEEK OTHER ASSISTANCE ON MY OWN. I UNDERSTAND THAT THE AGENCIES MAKE THE ELIGIBILITY DETERMINATION REGARDING MY APPLICATION, AND MEDASSIST CANNOT GUARANTEE ANY RESULTS. I UNDERSTAND THAT MEDASSIST CAN WITHDRAW AS MY DESIGNATED REPRESENTATIVE AT ANY TIME BY NOTIFYING THE APPLICABLE AGENCIES IN WRITING AND SHALL ALSO NOTIFY ME IN WRITING OF SUCH WITHDRAWAL.

_____ _____

Applicant Signature ***Date***

If signed by an individual authorized by law to sign on behalf of the Applicant:

_____ _____

Legal Representative's Signature ***Date***

Description of Legal Representative's Authority (such as legal guardian): _____

AS THE DESIGNATED REPRESENTATIVE, MEDASSIST WILL PROTECT AND MAINTAIN THE CONFIDENTIALITY OF ANY INFORMATION PROVIDED BY THE AGENCY TO MEDASSIST, INCLUDING INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION AND FINANCIAL INFORMATION OF THE APPLICANT, PURSUANT TO THE REGULATIONS SET FORTH IN 42 CFR 435.923; 42 CFR 431 SUBPART F; 45 CFR 155.260(f), 42 CFR 447.10, AS WELL AS OTHER RELEVANT STATE AND FEDERAL LAWS.

_____ _____

Authorized Employee Signature ***Date***