Agent of Record (AOR) Change Request

ATRIO AOR Policy:

- The signing agent on an Application or a Plan Change form is recognized as the Agent of Record for that member.
- Members may elect to change their Agent of Record by completing this form AND by concurrently completing a Protected Health Information Disclosure (PHI) form and submitting them together to ATRIO.
- ATRIO reserves the right to review and determine AOR assignment requests on a case-by-case basis. Any approved AOR changes will take effect on January 1st the following year.
- AOR Change Request forms **MUST** be completed and submitted by the **member.**

Member Information	
Member Name (First, M.I., Last):	Date of Birth:
Member ID:	Phone:
Member Authorization of Agent of Record (AOR) Change	
I formally request this new agent to assist and represent me with all of my ATRIO Health Plans coverage. I understand that this agent is an independent contractor and not employed by ATRIO Health Plans, that this new agent will replace my prior Agent of Record and that this change will remain in effect until such time as I submit a new AOR Change Request or an Application or Plan Change form that conflicts with this AOR Change Request.	
Signature	
Member Signature:	Date:
Agent Information	
Former Agent Name:	
New Agent Name:	Agent NPN:

Please complete and sign this form, along with an Protected Health Information Disclosure (PHI) form, and return to ATRIO Health Plans by:

Mail: ATRIO Health Plans
Attn: Agent Desk
2270 NW Aviation Dr #3
Roseburg, OR 97470

Fax: 1 (541) 672-8670

Email: AgentDesk@atriohp.com

Internal Use Only			
AOR Receipt Date:		Marketing Approver:	
AOR Effective Date:		Date Approved:	

PROTECTED HEALTH INFORMATION DISCLOSURE AUTHORIZATION

This form is used to confirm permission for ATRIO Health Plans and related entities to discuss or disclose your personal information, including your Protected Health Information, to a particular person (or persons) who acts as your Authorized Representative.

This document is available in alternate formats or for persons with special needs, please call 1 - 877-672-8620 (TTY 711) to request this service.

Please make sure to complete both sides of the form and sign it at the bottom of page 2. Send the completed form back to ATRIO.

Fax: (541) 672-8670 | **Mail:** ATRIO Health Plans, 550 Hawthorne Ave SE, Suite 140, Salem, OR 97301

SECTION 1: ATRIO MEMBER INFORMATION

Name (First MI Last):	Birth Date: ___/___/_____	Member ID #:	
Address:	City:	State:	Zip Code:
Email address:	Home Phone #:	Cell Phone #:	

SECTION 2: REQUEST TYPE

☐ **New Request:** This is a request to assign a new Authorized Representative(s).

☐ **Replace an Existing Request:** This is to replace a previously approved Authorized Representative.

☐ **Revoke an Existing Request:** This form is to request termination of a previously approved Authorized Representative. Enter an effective date for the termination:____/___/_____

Please Note: Any new request forms will automatically replace any existing requests previously approved.

SECTION 3: AUTHORIZATION

I authorize ATRIO Health Plans to discuss and disclose my personal information to the Authorized Representative(s) named below for the purpose of assisting with, or facilitating, enrollment, the coordination of services or payment of my health plan benefits. I understand that I have the right to limit the type of information that may be given to the Authorized Representative(s).

Instructions: Select any items below that you <u>WANT DISCLOSED</u> to the Authorized Representative(s). Please note, if you do not check any boxes, the form will be returned as incomplete.

☐ Medical records
☐ Mental health records
☐ HIV/AIDS tests or results
☐ Communicable diseases
☐ Alcohol / substance abuse treatment
☐ Genetic testing tests and results
☐ Claims information
☐ Prior authorization information
☐ Enrollment, eligibility, benefit information
☐ Premium dues and payment information
☐ Other (please specify): _____

SECTION 4: AUTHORIZED REPRESENTATIVE(S)

1st Authorized Representative			
Name (First MI Last):	Relationship (if any) to Member:		
Home Phone #:	Cell Phone#:		
Address:	City:	State:	Zip Code:
2nd Authorized Representative			
Name (First MI Last):	Relationship (if any) to Member:		
Home Phone #:	Cell Phone #:		
Address:	City:	State:	Zip Code:

SECTION 5: MEMBER'S SIGNATURE/AUTHORIZATION CONFIRMATION

Your Rights to Authorized Use and/or Disclosure

Please read the information below carefully

I understand that:

- ATRIO Health Plans general policy is to **not** disclose my personal information to other parties, except those directly involved in my care, without my written authorization or as permitted or required by law.
- This form will **not** alter the manner in which ATRIO Health Plans processes my benefits, payments, enrollment forms or my eligibility for benefits.
- If my Authorized Representative is **not** a health care provider or another entity subject to federal or applicable state privacy laws, those privacy laws may no longer protect my personal information, and my Authorized Representative may further disclose my personal information without my authorization.
- I understand that this authorization does **not** provide my Authorized Representative with any authority, either implied or direct, over any treatment or direct-care decisions.
- I have the right to **revoke or end** this authorization at any time and must do so in writing or by submitting a new form with updated information.
- If I revoke this authorization, it will **not** affect any action ATRIO Health Plans or related entities have taken prior to receiving my written notice to revoke.
- I may request a copy of this signed form.
- If I have questions about this form, I may contact ATRIO Health Plans at **1-877-672-8620** (TTY 711), daily from 8 a.m. to 8 p.m. local time.

By signing this form, I understand and agree that ATRIO Health Plans, on behalf of itself and its related entities, may release my personal information as stated above to the Authorized Representative(s) listed on this form. I have had full opportunity to read and understand the contents and requirements of this authorization.

Member's Signature:_____ **Date:** _____

Unless revoked in writing, this Authorization shall remain in force andeffect until it expires two years from the date of signature or until the following date:____/____/ _____

NOTE: If the member cannot sign this form, a legal representative may sign, complete, and return this form on behalf of the member. A legal representative is someone who has the legal right to sign for the member. Please attach proof that you are the member's legal representative (e.g. Power of Attorney documentation).