Providence Health Assurance

MEMBER AUTHORIZATION FORM
FOOMKA OGOLAANSHAHA XUBINKA

Buuxi foomkan si aad ugu oggolaato Providence Health Assurance (PHA) in ay macluumaadkaaga caafimaadka la wadaagto shaqsi (yada) kale. Fadlan isticmaal kaarkaaga aqoonsiga xubinka (ID) si uu kaaga caawiyo buuxinta macluumaadka qaybta A.

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PART A: MEMBER INFORMATION *(Provide your name and personal information)* **QAYBTA A: MACLUUMAADKA XUBINKA *(Bixi magacaaga iyo macluumaadkaaga shakhsi ahaaneed)***		
Member Last Name Magaca Ugu Dambeeya ee Xubinka	Member First Name Magaca Koowaad ee Xubinka	Middle Initial Magaca Dhexe Xarafka Hore
Member Date of Birth Taariikhda Dhalashada ee Xubinka	Member Identification Number (see your ID card) Nambarka Aqoonsiga Xubinta (Kafiiri kaarkaaga aqoonsiga)	Group Number (see your ID card) Nambarka Kooxda (fiiri Kaarkaaga aqoonsiga
Member Home/Street Address Guriga Xubinka/ Ciwaanka Wadada	City, State, and Zip Code Caasimadda, Gobolka, iyo koodhka Boostada	Preferred Phone Number Lambarka Taleefanka ee la door biday

PART B: INDIVIDUAL(S) WHO MAY RECEIVE MY INFORMATION *(Name of the individual(s) you are authorizing to receive your health information)*
QAYBTA B: SHAKHSI (YADA) HELI KARA MACLUUMAADKAYGA *(Magaca Shakhsiga(yada) aad u ogolaatay in ay helaan macluumaadkaaga caafimaad)*

I understand the below-named individual(s) must be 18 years of age or older.
Waxaan fahamsanahay in shakhsiga(yada) magaciisu hoos ku qoran yahay uu noqdo 18 jir ama ka weyn.

1. Name of authorized individual: _____
1. Magaca shakhsiga la oggolaaday: _____

Relationship to Member: ☐ Spouse ☐ Domestic Partner ☐ Friend ☐ Caretaker ☐ Broker ☐ Other
Xiriirka uu qofku la leeyahay Xubinka: ☐ Xaas ☐ Lamaane Xariir dheer leh ☐ Saaxiib ☐ Daryeele ☐ Dallaal ☐ Kuwa kale

2. Name of authorized individual: _____
2. Magaca shakhsiga la oggolaaday: _____

Relationship to Member: ☐ Spouse ☐ Domestic Partner ☐ Friend ☐ Caretaker ☐ Broker ☐ Other
Xiriirka uu qofku la leeyahay Xubinka: ☐ Xaas ☐ Lamaane Xariir dheer leh ☐ Saaxiib ☐ Daryeele ☐ Dallaal ☐ Kuwa kale

3. Name of authorized individual: _____
3. Magaca shakhsiga la oggolaaday: _____

Relationship to Member: ☐ Spouse ☐ Domestic Partner ☐ Friend ☐ Caretaker ☐ Broker ☐ Other
Xiriirka uu qofku la leeyahay Xubinka: ☐ Xaas ☐ Lamaane Xariir dheer leh ☐ Saaxiib ☐ Daryeele ☐ Dallaal ☐ Kuwa kale

PART C: PURPOSE OF MY AUTHORIZATION *(Select your reason for making this authorization by checking the appropriate box below)*
QAYBTA C: UJEEDADA OGGOLAANSHAHAYGA *(Dooro sababta aad oggolaanshahan u samaysay adiga oo calaameeynaya sanduuqa hoose ee ku habboon)*

☐ Member Request (personal reason)
☐ Codsiga xubinKa (sabab shakhsiyeed)

☐ Other (please specify): _____
☐ Kuwa kale (fadlan caddee): _____

PART D: INFORMATION THAT CAN BE SHARED BY PHA *(Select the information you are authorizing to release by checking the appropriate box(es) below)*
QAYBTA D: MACLUUMAADKA UU SOO BANDHIGI KARO PROVIDENCE HEALTH ASSURANCE (PHA) *(Dooro macluumaadka aad oggolaatay inaad siidayso adiga oo calaameeynaya sanduuqa(yada) ku haboon ee hoose)*

☐ Appeals
☐ Codsiyada

☐ Benefits and Coverage
☐ Faa'iidooyinka iyo Caymiska

☐ Claims and Payment Information
☐ Sheegashooyinka iyo Macluumaadka Lacag-bixinta

☐ Clinical Notes
☐ Qoraalo Caafimaad

☐ Diagnosis and Procedure
☐ Ogaanshaha xanuunada iyo Habraacyada

☐ Eligibility and Enrollment
☐ Uqalmitaanka iyo Diiwaangelinta

☐ Financial
☐ Dhaqaalaha

☐ Premium Information/Resolve Billing Questions/Problems
☐ Macluumaadka Qiimaha Sare/Xalinta Su'aalaha/Dhibaatooyinka biilasha

☐ Referrals and Preauthorizations for Medical Services
☐ Gudbinta iyo Oggolaanshaha Adeegyada Caafimaadka

☐ Other (please specify): _____
☐ Kuwa kale (fadlan caddee): _____

PART E: SENSITIVE INFORMATION THAT CAN BE SHARED BY PHA ***(Write your initials on the line next to each type of sensitive information you are authorizing to share)***
QAYBTA E: MACLUUMAAD XASAASI AH OO UU SOO BANDHIGI KARO PHA***(Ku qor xarfaha hore xariiqda ku xigta nooc kasta oo macluumaad xasaasi ah oo aad ogolaatay inaad wadaagto)***

Haddii diiwaankayaga ay ku jiraan mid ka mid ah noocyada macluumaadka hoos ku taxan, sharciyo dheeraad ah oo la xidhiidha isticmaalka iyo siidaynta macluumaadka ayaa laga yaabaa inay khuseeyaan.

*******Waxaan fahamsanahay in qaybaha macluumaadka xasaasiga ah qaarkood, oo ay ku jiraan kuwa la xiriira Aalkoloda/ isticmaalka maandooriyaha, lagu ilaaliyo sharciyada federaalka iyo kuwa gaarka ah ee gobolka oo aan la shaacin karin ogolaanshahayga qoran la'aanteed haddii aan si kale loo sheegin sharciyada iyo xeerarka. Waxaan fahamsanahay oo aan aqbalay in macluumaadka hoose kaliya la shaacin doono haddii aan* ***ku qoro xarfaha hore ee*** *xariiqda ku xigta macluumaadka xasaasiga ah ee la caddeeyey.*

_____ HIV (testing and treatment)
Fayraska difaaca jirka aadanaha (HIV) (baaritaan iyo daaweyn)

_____ Mental Health Data and Records
Xogta iyo Diiwaanada Caafimaadka Maskaxda

_____ *Alcohol/Drug/Substance Use (diagnosis, treatment, referral information)
*Aalkolo/Daroogo/ Isticmaalka Maandooriyaha(ogaanshaha cudurada, daaweynta cudurada, gudbinta macluumaadka)

_____ Maternity/Pregnancy (reproductive health)
Dhalmada/Uurnimada(Caafimaadka Taranka)

_____ Genetic Information (services or tests)
Xogta Jeneetik (adeegyo ama tijaabooyin)

_____ Sexually Transmitted Illness/ Disease (testing and treatment)
Xanuunada galmada lagu kala qaado/cudurka (baaritaanka iyo daaweynta)

Please note: To parents/legal guardians of minors, some state laws may prohibit PHA from acting on your request about Sensitive Information without written authorization from the minor member.
Fadlan ogow: Waalidiinta/masuulka sharciga ah ee ilmaha yaryar, sharciyada gobolka qaarkood ayaa laga yaabaa inay ka mamnuucaan Providence Health Assurance (PHA) inay ku dhaqanto codsigaaga ku saabsan macluumaadka xasaasiga ah iyada oo aan oggolaansho qoran laga helin xubinka yar.

Minor Member's Signature *Saxiixa Xubinka Yar*		*Date* *Taariikhda*

PART F: PERMISSION TO ACT ON MY BEHALF ***(You may authorize the individual(s) named in Part B to perform administrative functions on your behalf as indicated below)***
QAYBTA F: OGGOLAANSHAHA IN LAGU QABTO AY TAHAY MATALAADAYDA ***(Waxaa laga yaabaa inaad u ogolaato shaqsi (yada) lagu magacaabay Qaybta B inay qabtaan hawlo maamul iyagoo magacaaga ku hadlaya sida hoos lagu tilmaamay)***

☐ Request a new ID card
☐ Codso kaarka aqoonsiga cusub

☐ Change my address
☐ Beddel ciwaankayga

☐ Inquire/choose/change my primary care provider
☐ Weydii/dooro/beddel bixiyahayga daryeelka aasaasiga ah

☐ Enroll/disenroll me from the plan
☐ Iga diwaangeli/iga bixi qorshaha caafimaadka

☐ Correct missing/erroneous demographic information (age, gender, marital status, race)
☐ Sax xogta guud ee maqan/qaldan (da'da, jinsiga, heerka guurka, isirka)

PART G: DATE YOUR AUTHORIZATION EXPIRES (This authorization will remain in effect for three (3) years from the date it is signed unless you specify an earlier expiration date)
QAYBTA G: TAARIIKHDA OGGOLAANSHAAGU UU DHACAYO (Ogolaanshahan waxa uu sii jiri doonaa saddex (3) sano laga bilaabo taariikhda la saxiixay ilaa aad cadeyso taariikhda dhicitaanka hore)

☒ Three (3) years
Saddex (3) sano

☐ Other/earlier expiration date (please specify):
Taariikhda dhicitaanka kale/hore (fadlan caddee): _____

Deganeyaasha California: Foomka oggolaanshaha ee California guud ahaan wuxuu dhacaa hal (1) sano laga bilaabo taariikhda la saxiixay ilaa waqti kale oo dhicis ah la caddeeyo. Taariikhda dhicitaanka ugu badan ee ay ogolaato Providence Health Assurance PHA waa saddex (3) sano.

PART H: REVOCATION AND ACKNOWLEDGEMENT ***(Your rights related to this authorization, including the right to revoke your authorization)***
QAYBTA H: KA NOQOSHO IYO QIRITAAN ***(Xuquuqdaada la xidhiidha oggolaanshahan, oo ay ku jirto xaqa aad u leedahay inaad kala noqoto oggolaanshahaaga)***

Waxaad xaq u leedahay inaad ka noqoto oggolaanshahan qoraal wakhti kasta ka hor taariikhda uu dhacayo. Haddii aad ka noqoto oggolaanshahaaga, macluumaadkaaga looma isticmaali doono ama looma sii dayn doono ujeedooyinka lagu sheegay oggolaanshahan, marka laga reebo tillaabo kasta oo ay Providence Health Assurance (PHA) horay u qaadday iyadoo lagu saleynayo oggolaanshahaagi hore. Isticmaalka ama daah-furka kasta oo lagu sameeyay oggolaanshahaaga lagama noqon karo.

Si loogu daro shaqsiyaadka la ogolaaday ama loogu sameeyo ogolaanshahaaga isbedelo kale, fadlan buuxi oo soo gudbi foom cusub oo oggolaansho. Si aad ula noqoto oggolaanshaha jira, fadlan soo dir codsi qoraal ah si aad uga noqoto foomka hadda ku jira faylka. Kanoqoshadu waxay dhaqan gali doontaa isla marka ay Providence Health Assurance (PHA) hesho oo ay ka shaqeyso codsigaaga qoran. Codsigaagu waa inuu ku jiraa magacaaga oo dhammaystiran, lambarka aqoonsiga xubinka, iyo taariikhda dhalashada waana in lagu soo diraa:Providence Health Assurance ee P.O. Box 5548, Portland, Oregon, 97228-5548.

Markaad saxiixdo Qaybta I, waxaad qirayaa oo aqbalaysaa kuwa soo socda:

"Waan fahmay, kuraacay, oon oggolaaday in Providence Health Assurance ay isticmaasho oo ay shaaciso macluumaadkayga sidaan kor ku tilmaamay. Waxaan qirayaa in aan ku saxiixayo foomkan oggolaanshaha rabitaankayga xorta ah. Waxaan fahamsanahay in Providence Health Assurance aysan u baahnayn inaan u saxiixo foomka oggolaanshaha si aan u helo daawaynta, lacag bixinta, ama aan ugu qalmo faa'iidooyinka.

Waxaan fahamsanahay in mar haddii macluumaadkayga la wadaago, laga yaabo in uu isticmaalo oo uu shaaciyo qofka loo ogolaaday oo aan lagu ilaalin karin sharciga federaalka. Si kastaba ha ahaatee, waxaan sidoo kale fahamsanahay in sharciga federaaliga ama gobolka uu xaddidi karo in dib loo shaaciyo baaritaanka Fayraska difaaca jirka aadanaha (HIV) ama macluumaadka natiijada, macluumaadka caafimaadka dhimirka, macluumaadka hiddaha iyo ogaanshaha daroogada/aalkolada, daaweynta ama macluumaadka gudbinta."

PART I: MEMBER AUTHORIZATION ***(To finish your authorization, sign your name and write the date below)***
QAYBTA I: OGGOLAANSHAHA XUBINTA ***(Si aad u dhammayso oggolaanshahaaga, saxiix magacaaga oo ku qor hoos taariikhda)***

Member's Signature *Saxiixa Xubinka*	*Date* *Taariikhda*

Member's Designated Legal Representative/Guardian Signature
Saxiixa Wakiilka Sharciga ee Xubinta Loo Magacaabay/Saxiixa masuulka

Date
Taariikhda

Relationship to Member: ☐ *Parent of a Minor* ☐ **Legal Guardian* ☐ **Power of Attorney*
Xiriirka uu qofku la leeyahay Xubinka: ☐ *Waalidka ilmaha yar* ☐ **masuulka sharciga ah* ☐ **Dukumentiga Hay'adda Sharciga*

**If this form is signed by someone other than the member, please attach authorizing legal documentation of guardianship or power of attorney.*
**Haddii foomkan uu saxeexo qof aan ahayn xubinka, fadlan ku soo lifaaq dukumeenti sharci ah oo ku saabsan mas'uulnimada ama Dukumentiga Hay'adda Sharciga.*

PART J: RETURN THE COMPLETED FORM TO PROVIDENCE HEALTH ASSURANCE
QAYBTA J: KU SOO CELI FOOMKA LA BIIXIYEY PROVIDENCE HEALTH ASSURANCE

Iimayl:	Fakiska:	Boostada:
memberauthorizationrequest@providence.org	503-574-8116	Providence Health Assurance Attn: Adeegga Macmiilka P.O. Box 5548 Portland, Oregon 97228-5548

Haddii aad qabto wax su'aalo ah, fadlan ka wac Providence Medicare Advantage Plans lambarka 503-574-8000 ama 1-800-603-2340. Isticmaalayaasha TTY waa inay wacaan 711. Waxaan furnahay toddoba maalmood usbuucii, inta u dhaxaysa 8 subaxnimo iyo 8 galabnimo (Waqtiga Baasifigga). Inta u dhaxaysa 1*da Abriil* ilaa 30*ka Sebteembar* waxaanu xirannahay Sabti iyo Axad kasta.

FADLAN U HAYSO NUQUL KAMID AH FOOMKAN DIIWAANADAADA