Clear Form

Physicians Mutual®
Insurance for all of us.®

Physicians Mutual Insurance Company, Inc.
Claim Services
PO Box 2018
Omaha, NE 68103-2018 1.800.228.9100

# HIPAA Authorization for Claim Processing Purposes

## Please Check the Appropriate Company

☐ **Physicians Mutual Insurance Company, Inc.** ☐ **Physicians Life Insurance Company**
☐ **Physicians Select Insurance Company**

I, the undersigned, authorize any health plan, licensed physician, medical practitioner, hospital, clinic, medical or medical related facility, pharmacy, pharmacy benefit manager, the Veteran's Administration, insurance company, MIB, Inc., consumer reporting agency, employer or Government agency to disclose medical information about me or my minor children.

This authorization was prepared for the purpose of obtaining medical and non-medical information necessary to process a claim for benefits. The information subject to this authorization includes any and all medical and non-medical information being requested by Physicians Mutual Insurance Company, Inc. or Physicians Life Insurance Company or Physicians Select Insurance Company for the purpose stated above, as well as any information provided to Physicians Mutual Insurance Company, Inc. or Physicians Life Insurance Company or Physicians Select Insurance Company on previous applications. This authorization includes information about drug and alcohol use, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted disease, and mental illness. This authorization excludes psychotherapy notes and any genetic information, as defined by GINA, including any family medical history. **The information authorized in this release may include records which may indicate the presence of a communicable or non-communicable disease.**

Persons or entities employed by or authorized by Physicians Mutual Insurance Company, Inc. or Physicians Life Insurance Company or Physicians Select Insurance Company to perform tasks related to the claims process are hereby authorized to use the medical and non-medical information covered by this authorization. I understand that if the person or entity who receives this information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Physicians Mutual Insurance Company, Inc. or Physicians Life Insurance Company or Physicians Select Insurance Company or, so long as Physicians Mutual Insurance Company, Inc. or Physicians Life Insurance Company or Physicians Select Insurance Company has a legal right to contest a claim under the coverage or contest the coverage itself. Revocation requests must be sent in writing to: ATTN: Claims Administration Department Manager, Physicians Mutual/Physicians Life Insurance Company or Physicians Select Insurance Company, PO Box 2018, Omaha, NE 68103-2018.

I understand that Physicians Mutual Insurance Company, Inc. or Physicians Life Insurance Company or Physicians Select Insurance Company cannot condition the payment of a claim on my signing this authorization. This authorization will expire upon the final action related to the claim for which this authorization is signed. A copy of this authorization may be used in place of the original. I acknowledge that I or my authorized representative has received a copy of this authorization.

If this authorization is signed by my personal representative, that individual's authority to act on my behalf is described below.

_____ _____
(Print) Name of Individual Whose Information is covered by This Authorization — Date of Birth

**X** _____ _____
Signature of Individual — Date

_____
(Print) Name of Personal Representative of Individual Whose Information is Covered by This Authorization

_____ _____
Signature of Personal Representative of Individual Whose Information is Covered by This Authorization — Date

_____
Relationship of Representative to Individual

Retain One Copy and Return a Completed Copy