

Fill out and return the attached form to allow us to talk about your care or payments with a designated representative.

Dear US Family Health Plan Member,

Attached is the “Permission to Allow Martin’s Point to Discuss My Health Care or Payment with My Designated Representative” form.

For timely processing of this form, please do the following:

- » Be sure to **complete all fields** on the form, including your **signature** and the **date**.
- » Check all the boxes at the top of the form that apply to your request.
- » Write your Member ID number (found on your Martin’s Point US Family Health Plan Member ID Card) in the box near the bottom labeled “Member ID.”

Incomplete forms will be returned.



Please mail completed forms to:

Martin’s Point Health Care
Attention: USFHP Member Services/HIPAA
PO Box 9746
Portland, ME 04104-5040