COMMUNITY HEALTH CHOICE

Producer of Record Transfer Form
Current or Future Effective Date Only

Effective _____ (MM/DD/YYYY), I appoint _____ as my producer of record. As my producer of record and as a business associate of Community Health Choice, Inc. my producer of record will have access to my Protected Health Information (PHI) related to insurance support functions, such as membership maintenance information, plan benefit information and transactions, new product information, and enrollment and disenrollment information.

I am aware that the above producer's access to my PHI maintained by Community Health Choice excludes access to other types of information, including claim and, or medical information. A separate HIPAA – compliant written authorization form is required to provide other types of information, including claims or medical information to producers of record.

Policyholder's Printed Name: _____

Policyholder's Signature: _____

Policy Holder's Member ID: _____

Producer Printed Name: _____

Producer ID/NPN Number: _____

Date: _____

Reason for Request: _____

_____

Your request cannot be considered if the form is incomplete.

Community reserves the right to limit transfers.

Please return this form to:

Community Health Choice
2636 South Loop West
Attn: Sales and Marketing/Agent Information
Houston, TX 77056