

Libby Medical Program

Sponsored by W. R. Grace & Co.

Participant Application

TO BE COMPLETED BY APPLICANT

Applicant Name: _____ Applicant Social Security Number: _____ - _____ - _____

Applicant Current Address (Mailing) _____ Apt: _____
Street
City: _____ ST: _____ Zip: _____

Phone Number: (Day) _____ (Evening): _____ Cell: _____

Date of Birth: _____ - _____ 19_____ Were you ever employed at the Grace Mine or Mill in Libby, MT? Yes No

❖ If yes, when were you employed? From: _____ to _____
(mm/dd/yyyy) (mm/dd/yyyy)

Prior to January 1, 2000, did you live or work within a 20 miles radius of the Grace Mine or Mill in Libby, MT? Yes No

❖ If yes, at what address (street) _____ Apt: _____
(City) _____ (ST) _____ Zip: _____

When did you live at this address? From: _____ to _____
(mm/yyyy) (mm/yyyy)

Were you a spouse or legal dependent of someone who worked in the Grace Mine or Mill in Libby, MT? Yes No

❖ If yes, name of Grace Employee: _____

Are any other members of your family receiving benefits for treatment under the Libby Medical Program? Yes No

❖ If yes, please provide the following information on each member receiving benefits and/or treatment.

Member's Full Name	M/F	Date of Birth	Current Address	Relationship

Do you currently smoke? Yes No If yes, for how long? _____ years How much? _____ pack/day

If no, did you ever smoke? Yes No If yes, for how long? _____ years How much? _____ pack/day

Are you insured by any other medical insurance, Medicaid or Medicare? Yes No

❖ If yes, please provide the following information:

Name of Insurance Company: _____ Policy No: _____

I certify the above information to be true and complete I understand by completion of this application and the authorization below that the Libby Medical Program only provides benefits for asbestos related diseases.

Applicant's Signature: _____ Date: _____

Print Applicant's Name: _____

Authorization and Attending Physician's Statements must also be completed See Page 3

This authorization is being provided to you pursuant to the Health Insurance Portability & Accountability Act (HIPAA) Privacy regulations. This authorization addresses the medical information that will be used and disclosed about you in order for you to be enrolled in the Libby Medical Program and in order for the Libby Medical Program to manage its ongoing requirements

The only purposes for which the information is to be released to the below listed entities is as follows.

To make determinations with regard to enrollment in the Libby Medical Program, and for purposes of the treatment of Program members payment of fees related to those services and the administration of the Libby Medical Program including, but not limited to, for purposes of care coordination, claims payment, quality assurance, and audits required to manage the Libby Medical Program.

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize the use and/or disclosure of my protected health information as described below. Protected health information is health information that identifies or can be used to identify me, that relates to my health, the health care provided to me, or payment for healthcare provided to me.

1. My authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization.
 - All medical information that will be helpful to determine if the applicant has an asbestos-related condition or illness
2. The following persons (or classes of persons) are authorized to use and/or disclose my protected health information, but only for the purposes specified under item above.
 - All providers responsible for the diagnosis and/or treatment of asbestos-related conditions or asbestosis
 - Plan Sponsor – W. R. Grace & Company
 - Health Plan – The Libby Medical Program
 - Health Network America and its Business Associates
3. The use and/or disclosure of my protected health information may be made to the following persons (or classes of persons), but only for the purposes specified under item 1.
 - All providers responsible for my diagnosis and/or treatment of asbestos-related conditions or asbestosis
 - Plan Sponsor – W. R. Grace & Company
 - Health Plan – The Libby Medical Program
 - Health Network America and its Business Associates
4. I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information might be re-disclosed and might no longer be protected.
5. I understand that I have a right to revoke this authorization at any time, in the manner described in the Notice of Privacy Practices.

However a revocation will not be effective to the extent that Plan Sponsor or Health Network America may already have used or disclosed my protected health information in reliance on the authorization.
6. This authorization expires upon my death or termination from the Libby Medical Program. However, upon my death or termination from the Libby Medical Program all medical records up to and including the date of my death or date of my termination from the Libby Medical Program may be released so that any final, eligible medical claims may be paid.
7. I understand that I have been asked to sign this authorization, prior to enrollment in the Libby Medical Program, so that my protected health information may be used by and/or disclosed to the Libby Medical Program and to Health Network America to make an eligibility or enrollment determination or for its underwriting or risk rating determinations. This authorization is NOT for use or disclosure of psychotherapy notes. I also understand that if I refuse to sign this authorization, the Program might deny enrollment in the Program or eligibility for benefits.
8. I understand that if the Libby Medical Program has requested this authorization, and that the Libby Medical Program is required to give me a copy of this authorization after I have signed it.

Signature

Date

Print Name or Personal Representative's Signature

Description of Representative's Authority to Act for Enrollee

Print Name of Personal Representative

Date

**Attending Physician's Statement Identifying an Asbestos-Related, Qualifying
Medical Condition**

Patient's Name: _____ Age: _____

Please provide copies of most recent reports:

- ▶ X-ray;
- ▶ CAT scan of chest (if done);
- ▶ Pulmonary Function Testing (if done)

When did you first see this applicant for an asbestos related medical condition? _____
Date: _____

To the best of my knowledge, this patient has a qualifying medical condition as described by the Libby Medical Program and may be eligible to receive benefits from the Libby Medical Program.

I understand I am legally obligated to complete this form with facts I know are true or to not omit facts I know are important for the determination of eligibility and for the accurate claim adjudication for the Libby Medical Program. Therefore, I certify the above information to be true and complete.

Please note: Rubber stamped or digitized signatures will not be accepted.

Attending Physician Signature Date

Print Attending Physician Name Tax Identification Number

Street Address

City State Zip Code

Mail Application form to:
HNA/Triveris
Libby Medical Program
P. O. Box 65
West Long Branch, NJ 07764

For questions regarding this program call 1-888-563-1564 ext 127

Office Use Only

Effective Date of Coverage: _____ Date Processed: _____

Authorization: _____