COVER MONTANA

Updated: 11/2024

Montana Primary Care Association &
Cover Montana
Navigator Authorization Form

Montana Primary Care Association
1805 Euclid Ave. Helena, MT 59601

I, _____, give my permission, or _____ [Insert name of authorized representative], my legal or Marketplace authorized representative acting on my behalf ("authorized representative"), gives permission to Cover Montana Navigators to create, collect, disclose, access, maintain, use, and/or store my personally identifiable information (PII) and/or the PII of my authorized representative, to perform the following Navigator duties.

- Inform me and/or my authorized representative about the full range of Marketplace health coverage options and insurance affordability programs for which I'm eligible;
- Help me complete my application for health coverage in a Qualified Health Plan (QHP), which are health plans available through the Marketplace or Healthcare.gov;
- Help me enroll in a QHP or in an insurance affordability program. These programs can help me or my family pay for health coverage, and include public programs, such as Montana Medicaid or Healthy Montana Kids, premium tax credits, and cost-sharing reductions.

I acknowledge that I received a list of Navigator roles and responsibilities, outlined in Attachment A: Navigator Roles and Responsibilities.

I understand that Cover Montana Navigators have the following responsibilities and will perform the following functions:

- Cover Montana Navigators will inform me and/or my authorized representative about the full range of Marketplace health coverage options and insurance affordability programs for which I'm eligible, will help me apply for health coverage in a QHP through the Marketplace and for insurance affordability programs, and will help me enroll in a QHP or in an insurance affordability program.
- Cover Montana Navigators will inform me of any possible conflicts of interest they might have.
- Cover Montana Navigators can't choose a health insurance plan for me.

Cover Montana Navigators are required to act in my best interest.

Cover Montana Navigators will follow privacy and information security standards when creating, collecting, disclosing, accessing, maintaining, storing, and/or using my PII and/or the PII of my authorized representative. Information about these standards will be provided.

Cover Montana Navigators aren't required to maintain or store any of my PII and/or the PII of my authorized representative, other than this authorization form, but if Cover Montana Navigators do maintain or store my PII, they will follow privacy and information security standards.

I and/or my authorized representative do not need to provide Cover Montana Navigators contact information, unless I want Cover Montana Navigators to follow-up with me on applying for or enrolling into coverage. My consent to follow-up is given by providing my phone number, email, and address below. Consent to follow-up by Cover Montana Navigators automatically terminates in 24 months.

I and/or my authorized representative may choose to continue to receive follow-up information, education, and other assistance with understanding and utilizing my health insurance from Cover Montana Navigators. This may include but is not limited to the following: assistance understanding a health plan, identifying a primary care provider, utilizing

preventive care, updating a Health Insurance Marketplace application, an/or reenrollment.

The assistance Cover Montana Navigators provide is based only on the information I and/or my authorized representative provide, and if the information provided is inaccurate or incomplete, Cover Montana Navigators may not be able to provide all the assistance available for my situation.

If Cover Montana Navigators are unable to assist me and/or my authorized representative, they will refer me or my authorized representative to another person who can help me (other Marketplace-authorized assistance personnel), or to the Marketplace call center.

Cover Montana Navigators will not charge me and/or my authorized representative a fee for any assistance provided.

I understand that I may revoke this authorization at any time and will notify Cover Montana Navigators if I choose to revoke my authorization. I make the following exemptions, limitations, or changes:

_____

_____

Required Section:
Signature of consumer
or legal representative:_____Date: _____
(circle one)

Optional Section, fill out if you want Cover Montana Navigators to follow up:

Phone Number: _____ Email Address: _____

Address: _____

Health Insurance Follow Up:

By initialing, _____ I and/or my authorized representative consent to receive information about health insurance which may include but is not limited to the following: understanding a health plan, identifying a primary care provider, utilizing preventive care, updating a Health Insurance Marketplace application, an/or reenrollment.