# Authorization for Release of Premium Billing Information to Veterans Administration (VA)

Member name: ____________________________ Member ID number: ______________________________

Member address:___________________________________________________________________________

Member telephone:________________________ Member date of birth: __________________________

**Effective _________________I request and authorize Fallon Health to release my monthly premium bill to the following VA office for payment:**

VA office name: ___________________________________________________________________________

Address: _________________________________________________________________________________

City:_________________________________ State: __________ ZIP:______________________________

Telephone:_________________________ VA office contact person: ____________________________

**The VA office agrees to be billed and be responsible for the Fallon Health monthly plan premium payments for the above listed member.**

______________________________________ _____________________

VA approval signature Date

**This request and authorization applies to personal information relating to premium billing information only.**

**I understand that:**

- All notices regarding premium payment change(s) or non-payment will be sent to me, and it will be my responsibility to contact the VA office to follow up on the change(s) or non-payment.
- I may withdraw my authorization at any time by submitting a written request to the Fallon Enrollment and Billing Department. If I do, I understand that my personal information may have already been released after I gave permission.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal or state privacy laws.
- I understand that this authorization will automatically expire on ________________ or one year from the date of signature.
- I understand that I have the right to refuse to sign this authorization and that my refusal will not result in the condition of treatment, payment, enrollment in Fallon or eligibility for benefits.

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information.

Member (or personal representative) signature: ____________________________________________

Print name: _______________________________________

Date: _____________________________

If signed by member's personal representative, please attach documentation of authority (e.g., power of attorney, signed authorization).

**Mail or fax completed form to:** Fallon Health
Enrollment and Billing Department
10 Chestnut St.
Worcester, MA 01608