

**Declining to Share Personal Health Information Use this form**:

If you do **NOT** want Medicare to share information with Prime Accountable Care, LLC about the care you have received from doctors or other healthcare providers for use in coordinating and improving the quality of your care. Your decision not to allow Medicare to share your personal health information with Prime Accountable Care, LLC means Medicare won’t share information with any ACOs in which any of your doctors or other healthcare providers participate.

Completing this form also overrides any previous decision you may have made about sharing your personal health information with another ACO. You can also call 1-800 MEDICARE (1-800-633-4227) instead of completing this form. TTY users should call 1-877-486-2048. Your decision not to share your personal health information with Prime Accountable Care, LLC and any other ACOs in which any of your doctors or other healthcare providers participate will remain in effect unless you communicate a changed preference to us, another ACO, or to Medicare directly through 1-800-Medicare.

You may change your decision not to share your personal information at any time. Your request will take effect in approximately 60 days. Please note that other ACOs in which any of your doctors or other healthcare providers participate may also contact you to ask your preferences about sharing your information with ACOs. If you are satisfied with your most recent response to such an inquiry, you do not need to do anything.

If you wish to change your preference, please contact us to request a copy of the Consent to Change Personal Health Information Preference form or call 1-800-MEDICARE and say that you want to change your preference about sharing your personal health information with ACOs or that you want to talk about ACOs. The online link for the form is: <https://www.medicare.gov/MedicareOnlineForms/PublicForms/CMS10106.pdf>

**Note:** If you are unsure of whether your personal health information is currently being shared with any ACOs for purposes of coordinating and improving the quality of your care, you may ask for that information through 1-800-MEDICARE.

 **Note:** Even if you don’t want to share your personal information for coordinating and improving the quality of your care with Prime Accountable Care, LLC or with any other ACOs in which any of your doctors or other healthcare providers participate, Medicare will still use your information for some purposes, including certain financial calculations and measuring the quality of care provided by Prime Accountable Care, LLC and/or those other ACOs.

Also, Medicare may share some of your personal health information with those ACOs as part of measuring the quality of care given by the healthcare providers in those ACOs.



 **How to Submit Your Preference:**

Fill out, sign and return this form to your provider’s office in person, or by mail to the following address: Prime Accountable Care, LLC, 28270 Franklin Rd., Southfield, MI. 48034 or call the office at: 1-888-509-5032, Fax: 1-888-509-5361. You can also Call 1-800-MEDICARE (1-800-633-4227) and say that you wish Medicare to stop sharing your personal information with ACOs, or that you want to talk about ACOs. TTY users should call 1-877-486-2048.

**Questions:**

 If you have any questions, please contact 1-800-MEDICARE and tell the operator you are asking about ACOs.

You may also call Prime Accountable Care, LLC call center at 1-888-509-5032 during regular business hours from 9:00 AM till 5:00 PM, Monday thru Friday.



**Your Information:**

Name (first and last name of the person with Medicare):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_\_\_\_\_\_\_\_

Mailing address (if different than above):

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_\_\_\_\_\_\_\_

**Check the box below to decline sharing personal health information with Prime Accountable Care, LLC.**

 **DO NOT** allow Medicare to share my personal health information for care coordination and quality improvement purposes with Prime Accountable Care, LLC in which any of my doctors or other healthcare providers participate. By checking this box, Medicare won’t share information with any other ACOs in which any of your doctors or other healthcare providers participate in.

Signature of person with Medicare or representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Check here if the person completing and signing this document is serving as a personal representative of the listed person with Medicare. Please attach the appropriate documentation to demonstrate your legal authority to execute this document on behalf of the person with Medicare (for example, Durable Medical Power of Attorney). This box should be checked only if someone other than the person with Medicare signed above.**

(Print) personal representative’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_\_\_\_\_\_\_\_

Phone number of personal representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal representative's relationship to the person with Medicare: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_