

**REQUEST FOR REVOCATION OF MY AUTHORIZATION  
TO USE THE HOME BUNDLE BENEFIT**

Member or Authorized Representative<sup>(1)</sup> name *(printed in block letter)*

Contract number:

Birth date *(month/day/year)*:

Address:

Phones: Home: \_\_\_\_\_ Cellular: \_\_\_\_\_ Other: \_\_\_\_\_

- **Revocation:** I hereby request revocation of the **AUTHORIZATION TO USE HOME BUNDLE BENEFIT** (“home bundle”) submitted to MCS Classicare (HMO) to the following person or entity:

\_\_\_\_\_  
*(name of the person or entity previously authorized)*

- I understand that this revocation will not affect the benefit on my coverage.
- This revocation is only valid to not use, receive and/or disclose specific information about the home bundle benefit.
- I understand that this document does not constitute a revocation of authorized representative under HIPAA.

\_\_\_\_\_  
**Signature of member or authorized representative<sup>(1)</sup>**

\_\_\_\_\_  
**Date** *(month/day/year)*

<sup>(1)</sup> Authorized representative must include evidence regarding the legal capacity of representing the member (e.g., guardianship, court order, power of attorney, etc.)

\_\_\_\_\_  
**Name of witness** *(if needed)*

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date** *(month/day/year)*

**Confidentiality Notice:** This communication is privileged and confidential, and/or protected health information (PHI) or electronic protected health information (ePHI), and may be subject to protection under the law, including HIPAA. This communication is intended for the sole use of the individual or entity to whom it is addressed. If you are not the intended recipient, be advised that any use, disclosure, distribution, copying, or action taken in reliance on the contents of this communication is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for its return. H5577\_12000123\_C