Request for Certification of Billed Medical Expenses

To be able to process your request we require the following documentation:

- **If you are the patient:**
  - Complete Form sections: 1, 3 & 4
  - Valid Photo ID (e.g.: Driver's license, passport, identification card)
- **If you are the Authorized Representative:**
  - Complete **all** Form sections
  - Patient valid Photo ID (e.g.: Driver's license, passport, identification card)
  - Representative valid Photo ID
  - Written authorization from patient (handwritten signature by patient)
  - Power of Attorney (if written authorization is not available)
- **If you are the Authorized Representative (Patient Deceased)**
  - Complete **all** Form sections
  - Official Death Certificate
  - Patient valid Photo ID (e.g.: Driver's license, passport, identification card)
  - Representative valid Photo ID
  - And one (1) of the following: Affidavit of Heirship, Birth Certificate or Last Will and Testament
- **If patient is minor (under 21 years)**
  - Complete **all** Form sections
  - Representative valid Photo ID
  - Patient's Birth Certificate (if parent is requesting)
  - Legal guardian evidence (if person requesting is not the parent)
- **If patient is minor (emancipated under 21 years)**
  - Complete Form sections: 1, 3 & 4
  - Emancipation evidence
  - Valid Photo ID

Form and required documentation can be submitted by **email, fax, postal, or in person.**

- Email: certificacionesdegastos@aliviahealth.com
- Fax: (787) 925-1015
- Postal: P.O. BOX 246, Bayamon PR 00960
- Person: Amelia Industrial Park, Calle Diana Lot 18, Guaynabo

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Section 1: Patient Information	
Patient Name (Last, First, Middle initial):	Date of Birth (MM-DD-YYYY):
Mailing Address:	Phone Number:

Section 2: Requester Information	
Requester Name (Last, First, Middle initial):	☐ I am **not** the patient
Requester Phone Number:	Relationship with Patient:

What is your authority to access health information? (*Check the appropriate box and provide a copy of the supporting documents that confirm your authority to act on behalf of the patient.)*

☐ Parent or legal guardian of an individual under the age of 21 years.
☐ Nearest relative under the Mental Health Act.
☐ Personal representative of a deceased individual.
☐ Power of attorney has been granted by the patient.
☐ Written authorization has been given by the patient to make requests on his/her behalf.

Section 3: Requested Information

1. Dates of service requested:

   From (MM-DD-YYYY) _____

   To (MM-DD-YYYY) _____

2. Preferred Format for Receiving Copies:
   ☐ Printed copy - Pharmacy pick-up.
   ☐ Printed copy - Mail to address on Section 1.
   ☐ Email copy. Send the following email address:
   _____
   (*Information will be provided through a secure email message.)*

Section 4: Patient/authorized representative signature

I declare that all medical information provided is true and accurate. I understand that providing false or misleading information may affect processing and may result in penalties as permitted by law. **Important: If legal documentation is not on file with Alivia Specialty Pharmacy, a copy of legal documentation must be included with this form.**

_____
Patient Signature

_____
Date (MM-DD-YYYY)

_____
Authorized Representative Signature (if applicable)

_____
Date (MM-DD-YYYY)