IMMEDIATE FAMILY MEMBER TREATMENT CERTIFICATION FORM

This form is to be used when Start has reason to believe that a provider performed healthcare services to an immediate family member and charged Start for those services. You may use this form to certify that the treatment you received from a provider was not performed by an immediate family member.[1] Providers who are immediate family members are prohibited from billing for healthcare services that are provided to immediate family members. If Start discovers that a member has mislead or provided false information regarding the relationship between their provider and themselves, the member will be responsible to pay for their own medical claims and may have their policy terminated with Start.

If you need help completing the form, please contact our Personal Health Assistants (PHAs) at 800-894-9454 or support@starthealth.com.

When completed and signed please mail to: Start
P.O. Box 7009718
Sandy, UT 84070

You may also email this form to support@starthealth.com

Section I. Member Information			
Name of Member:	Group ID #:	Member ID #:	
Social Security Number:	Date of Birth (mm/dd/yyyy):		
Address:	City:	State:	Zip Code:
Telephone Number:			

Section II. Please provide details about the relationship between the member and provider.

[1] *See* R590-277-4(iv)(nn) for definition of Immediate Family Member.

Section III. Signature - This document must be signed by the member or the member's personal representative.	
I certify that the member was not treated by an immediate family member at any time that they have had a policy with Start. I certify, under penalty of perjury, that the suspected provider is not an immediate family member. I understand that I can only sign on behalf of a minor child under the age of eighteen (18).	
Signature:	Date: (mm/dd/yy)

Section IV. If Section III is signed by a Personal Representative, please complete the information below.	
If you are signing as a power of attorney, legal guardian, executor, or administrator, please attach a copy of the legal documents.	
Personal Representative's Name:	Relationship to Member:
Personal Representative's Address:	City:
Personal Representative's Phone Number:	Representative's Email:

Any changes to the form must be approved by the privacy officer: support@starthealth.com.