

Post-Service Appeals — Designation of Authorized Representative

I, _____, (*your name*) do hereby appoint,

(*your Authorized Representative*) (*hereinafter "my Authorized Representative"*) to act on my behalf in pursuing a benefit claim, specifically, my claim(s) for
_____. (*insert claim control number from EOB*)

My Authorized Representative shall have full authority to act and receive notices on my behalf with respect to an initial determination of the claim, any request for documents relating to the claim, and any appeal of an adverse benefit determination of the claim.

I understand that in the absence of a contrary direction from me, G.E.H.A will direct all information and notices regarding the claim to which I otherwise am entitled, including benefit determinations, to my Authorized Representative **only**.

I am aware that the Standards for Privacy of Individually Identifiable Health Information set forth by the U.S. Department of Health and Human Services (the "Privacy Standards") govern access to medical/dental information.

IMPORTANT: Your signature below means that you understand and agree to the following:

- G.E.H.A may disclose protected health information (PHI) to the Representative, including, but not limited to history, physical, physician notes, nurses' notes, other treating providers, diagnosis, procedures, etc.
- The PHI disclosed to the Representative may include PHI you may consider to be sensitive information. (Please note there is no limit to the information the Authorized Representative may request in regards to the provider and name/dates of services documented above).
- If you sign this form, you may revoke the authorization at any time by notifying G.E.H.A in writing at the address shown above. Revoking this authorization will not have any effect on actions G.E.H.A took before receiving the revocation.
- G.E.H.A will not condition treatment, payment, enrollment or eligibility for benefits based on this form. Your signature is required to process the request for appeal, plan information, and/or PHI initiated by the Representative.
- Information disclosed as based on this form may be further disclosed by the Representative without your authorization and may no longer be protected by federal or state privacy regulations.
- This authorization is only valid for the duration of the appeal and will expire when the appeal is completed.

Date ____/____/____ Member ID _____
MM DD YYYY

Signature of patient or patient's guardian _____

Acknowledgement

I, _____ (*name of Authorized Representative*), have read the above Designation of Authorized Representative, and I hereby accept this designation and agree to act as Authorized Representative for _____ (*claimant's name*) with respect to the above defined claim.

Date ____/____/____
MM DD YYYY

Signature of Authorized Representative _____

Notices may be sent to the Authorized Representative at the following address:

Name _____

Street address _____ City _____ State _____ ZIP _____