APPOINTMENT OF AUTHORIZED REPRESENTATIVE FORM

Member Name _____ **Member ID Number** _____

I, _____ , appoint _____
Name of Member Name of Authorized Representative

to act on behalf of _____
Name of Member

in connection with any claim for coverage or benefits identified in case # _____ including receipt of any approval(s) or authorization(s) that are required before medical service(s). I authorize my representative to receive any and all information related to this case that is provided to me, and to act for me and for my minor dependent, if named above, in providing any information to the group health plan in relation to the disputed claims, approvals, or authorizations. This document is not intended to authorize access to any personal health information unrelated to the disputed claims, approvals, or authorizations.

Signature of Member _____ **Date** _____

Address: _____ Telephone Number: _____

_____

_____

I, _____ , hereby accept the above appointment.
Name of Authorized Representative

I am a/an _____
Relationship to member

Signature of Authorized Representative _____ **Date** _____

Address: _____ Telephone Number: _____

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