HIGHMARK. HEALTH OPTIONS

# Member Appeal Representation Consent Form

As a Highmark Health Options member, you can ask for an appeal. You can have a legal or acting representative help with your appeal. An appeal is a request for a review of a denied or limited health care service. This includes the:

- Type or level of service.
- Reduction, suspension, or termination of a service.
- Failure to provide a service in a timely manner.
- Highmark Health Options' denial to pay in whole or in part for a service.

Find more information in a document called "Notice of Adverse Benefit Determination" that was mailed to you.

**When to file your appeal:** This form must be completed and received at Highmark Health Options **within 60 days** of the date on the "Notice of Adverse Benefit Determination."

**How to submit this form:** Use the enclosed reply envelope to mail the completed form. If you do not have a reply envelope, mail to:
Highmark Health Options
Attn: Appeals and Grievances
P.O. Box 106004
Pittsburgh, PA 15230

**What happens next:** We will send you a letter letting you know we received your form. We will review the information you have sent to us.

## Use this form to consent to a legal or acting representative to help with your appeal.

Please fill in as much of the form as you can and include as much information as possible.

Be prepared to provide the following:

**Member information:** Find this on your member ID card.

**Member's legal or acting representative:** Provide information about the person you want to have as your representative.

**Service/claim information:** Tell us about the service, claim, or item about which you are appealing. Find this information on the "Notice of Adverse Benefit Determination."

**Description of appeal:** Tell us why you are requesting an appeal. Use additional paper if necessary.

**Signatures:** Sign the form or have your representative sign the form.

**Need help?**
Call Member Services at 1-844-325-6251 or read about the appeal process in your Member Handbook.

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## Member Information

| Today's Date | Member ID Number | Date of Birth |
|---|---|---|
| First Name | Last Name | Primary Phone Number |
| Street Address | | |
| City, State, ZIP | | |

## Member's Legal Representative If applicable.

| First Name | Last Name | Primary Phone Number |
|---|---|---|
| Street Address | | |
| City, State, ZIP | | |

## Member's Acting Representative

| First Name | Last Name | Primary Phone Number |
|---|---|---|
| Street Address | | |
| City, State, ZIP | | |

## Service/Claim Information

| Claim Number(s) | Reference/Authorization Number(s) If applicable. |
|---|---|
| Provider Name | Date(s) of Service(s) |

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## Brief description of services that may be appealed

_____

_____

_____

_____

_____

## Understanding Your Rights

I, or my legally appointed representative if I am under age 18 or legally incompetent, authorize the above-named acting representative to file an appeal on my behalf with Highmark Health Options. I understand the following:

1. I may not submit an appeal concerning the services/items listed in this consent form unless I or the above-named acting representative rescinds authorization in writing. I have the right to rescind authorization at any time during the appeal process.
2. I have read, or have been read, this authorization form and have had it explained to my satisfaction.
3. The information in the authorization form grants my consent to the above-named acting representative to file an appeal on my behalf.

| **Member Printed First and Last Name** | **Signature** | **Date** |
|---|---|---|
| | | |

If the member is under age 18 or unable to sign:

| **Representative Printed First and Last Name** | **Signature** |
|---|---|
| **Relationship to Member** | **Date:** |