Designation of an Authorized Representative

To: Member Appeals Department
P.O. Box 535095
Pittsburgh, PA 15253-5095

Patient's Name: Patient's Date of Birth:

Identification Number: Group Number:

Inquiry Number:

I, _____ do hereby authorize the Plan to disclose the
(Patient Name)

above information to _____,
(Name of Representative)

of _____,
(Address of Representative) (Telephone Number of Representative)

as my representative to participate in the Appeal process on my behalf.

I understand that, if the persons or organizations I authorize to receive and/or use the protected health information described above are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

I understand that the Plan may condition payment of a claim for specified benefits on my signing of this authorization (other than for psychotherapy notes) to allow other covered entities to disclose protected health information to the Plan that the Plan needs to determine payment of my claim.

The Plan, its subsidiaries, affiliates, employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Description of scope of representative's authority:

- ☐ Represent Patient's interest in First Level Review.
- ☐ Represent Patient's interest in Second Level Review.
- ☐ Represent Patient's interest in all possible appeals.
- ☐ Other (specify):

_____

Unless otherwise revoked, this authorization will expire on the following date, event, or circumstance:

(*Insert date, event, or circumstance----if no date, event or circumstance is included, this Authorization will expire one year after date of Patient signature)*

Expiration Date:_____

I understand that I have the right to revoke this designation at any time. Such revocation shall only become effective upon receipt by the Plan of written notice of my revocation.

Patient's Signature _____ Date____/____/____

Address: _____

_____

_____

You are entitled to a copy of this authorization after you sign it.