Designation of an Authorized Representative

To: Member Appeals Department
P.O. Box 2717
Pittsburgh, PA 15230-2717

Patient 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 _____
(Complaint or Grievance)

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 it 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.

If you are consenting to permit your health care provider to file an Act 68 Grievance on your behalf, please also complete and sign page three (3) of this form.

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 member 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.

Complete for Act 68 grievances only when provider is acting on member's behalf:

Health Care Provider Number: _____

I understand that if my health care provider files a grievance on my behalf, I cannot file a grievance for the same issue unless I rescind my consent in writing. I have the right to rescind my consent in writing at any time during the grievance process. In the event that my health care provider fails to file or pursue a grievance through the second level grievance process, this consent shall be deemed as having been automatically rescinded without further action on my part.

Once a health care provider assumes responsibility for filing a grievance, the health care provider may not bill the enrollee or the enrollee's legal representative for services provided that are the subject of the grievance until the external grievance review has been completed or the enrollee or the enrollee's legal representative rescinds consent for the health care provider to pursue the grievance.

If the health care provider elects to appeal an adverse decision of a CRE (Certified Review Entity), the health care provider may not bill the enrollee or the enrollee's legal representative for services provided that are the subject of the grievance until the health care provider chooses not to appeal an adverse decision to a court of competent jurisdiction.

I have read, or have been read this consent form, and have had it explained to my satisfaction. I understand the information in the consent form.

Patient or Patient's Legal Representative:
(If patient is a minor or legally incompetent)

_____

Signature Date

Relationship to patient

_____

Address_____

_____

Witness:

_____

Signature Date

Note: A health care provider may not require patient/patient's legal representative to sign a document authorizing the health care provider to file a grievance as a condition of providing a health care service.