

APPEALS - DESIGNATION OF AUTHORIZED REPRESENTATIVE

| I, | , do hereby appoint, (hereinafter ' | "my |
|---|--|-------------------------|
| Authorized Representative' | ") to act on my behalf in pursuing a benefit claim, specific | cally, my |
| | My Authorized representative s | |
| (Insert Claim N | Number, Situation, ETC) | |
| · · | nd receive notices, on my behalf with respect to an initial | |
| • | any request for documents relating to the claim, and any | |
| of an adverse benefit determ | | |
| of all adverse Belletit deteri | initiation of the claim. | |
| Lunderstand that in the abo | sence of a contrary direction from me, UMR will direct al | 1 1 |
| | garding the claim to which I otherwise an entitled, includi | |
| | | ng. |
| benefit determinations, to i | ny Authorized representative <u>only</u> . | |
| forth by the U.S. Departme govern access to medical in performance of his/her dut Protected Health Informati | eds for Privacy of Individually Identifiable Health Informent of Health and Human Services (the "Privacy Standard formation. I understand that in connection with the ties hereunder, my Authorized Representative may received in, as defined in the Privacy Standards, relating to the classics of my Protected Health Information to my Authorized Control of the Privacy Standards." | ls") re my aim. I |
| Date: | (Signature of patient or patient's guardian) | |
| Member ID: | | |
| | | |
| ACKNOWLEDGEMENT | | |
| T | 1 1.1 1 D ' .' (A.1 | |
| I, | , have read the above Designation of Authorpresentative) | orized |
| | | |
| - | y accept this designation and agree to act as Authorized | |
| Representative for | with respect to the above defined claim | m. |
| (Claima: | nt's name) | |
| | | |
| Date: | | |
| | (Signature of Authorized Representative) | |
| Notices may be sent to the | Authorized Representative at the following address: | |
| | | |
| Name | | |
| | | |
| Street Address | | |
| o | | |
| City, State & Zip Code | | |
| | | |