Post-Service Appeals – Designation of Authorized Representative

American Postal Workers Union Health Plan, AFL-CIO

6514 Meadowridge Road, Suite 195; Elkridge, MD 21075

I, ____, (*your printed name*) do hereby appoint,

____, (*printed name of your Authorized Representative*) (*hereinafter "my Authorized Representative*") to act on my behalf in pursuing a benefit claim, specifically, my claim(s) for:

Claim Control Number (*from Explanation of Benefits*)**:** ____

My Authorized Representative shall have full authority to act and receive notices on my behalf with respect to an initial determination of the claim, any request for documents relating to the claim, and any appeal of an adverse benefit determination of the claim.

I understand that in the absence of a contrary direction from me, APWU Health Plan will direct all information and notices regarding the claim to which I otherwise am entitled, including benefit determinations, to my Authorized Representative **only**.

I am aware that the Standards for Privacy of Individually Identifiable Health Information set forth by the U.S. Department of Health and Human Services (the "Privacy Standards") govern access to medical/dental information.

IMPORTANT: Your signature below means that you understand and agree to the following:

- APWU Health Plan may disclose Protected Health Information (PHI) to the Representative, including, but not limited to history, physical, physician notes, nurses' notes, other treating providers, diagnosis, procedures, etc.
- The PHI disclosed to the Representative may include PHI you may consider to be sensitive information. (Please note, there is no limit to the information the Authorized Representative may request in regards to the provider and name/dates of services documented above.)
- If you sign this form, you may revoke the authorization at any time by notifying APWU Health Plan in writing at the address shown above. Revoking this authorization will not have any effect on actions APWU Health Plan took before receiving the revocation.
- APWU Health Plan will not condition treatment, payment, enrollment or eligibility for benefits based on this form. Your signature is required to process the request for appeal, plan information, and/or PHI initiated by the Representative.
- Information disclosed as based on this form may be further disclosed by the Representative without your authorization and may no longer be protected by federal or state privacy regulations.
- This authorization is only valid for the duration of the appeal and will expire when the appeal is completed.

Member ID: ________________________________ **Date** *(Month/Date/Year)***:** ________________________

Signature of Patient or Legal Guardian of Patient: ____

Acknowledgement

I, ____ (*name of Authorized Representative*) have read the above Designation of Authorized Representative, and I hereby accept this designation and agree to act as Authorized Representative for ____ (*name of claimant*) with respect to the above defined claim.

Date *(Month/Date/Year)***:** ______________

Signature of Authorized Representative: ____

<u>Notices may be sent to the Authorized Representative at the following address</u>:

Name: ____

Street Address: ________________________________

City: ____________________________ **State:** ______________ **Zip:** ____________________

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