Humana Grievance and Appeal Department
APPOINTMENT OF AUTHORIZED REPRESENTATIVE FORM

Member Name _____ **Member ID Number** (to be completed by member) _____

I, _____ , appoint _____
Name of Member Name of Authorized Representative

to act on behalf of _____
Name of Member

in connection with any claim for coverage or benefits identified in case # _____ including receipt of any approval(s) or authorization(s) that are required before medical service(s). I authorize my representative to receive any, and all information related to this case that is provided to me, and to act for me and for my minor dependent, if named above, in providing any information to the group health plan in relation to the disputed claims, approvals, or authorizations. This document is not intended to authorize access to any personal health information unrelated to the disputed claims, approvals, or authorizations.

Important Information About Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization, *which relates only to information related to the appeal of the case described above,* at any time prior to its expiration date by notifying the Humana Grievance and Appeal department in writing, but the revocation will not have any effect on any actions that Humana took before it received the revocation.
- The duration of this authorization extends through all levels of internal appeal, unless I revoke the authorization prior to completion of the appeal process.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity. I have the right to seek assurances from the above-named persons/organizations authorized to receive the information that they will not redisclose the information to any other party without my further authorization.

_____ _____
Signature of Member* **Date***

Address: _____ Telephone Number: _____

_____

_____

I, _____ , hereby accept the above appointment.
Name of Authorized Representative

I am a/an _____
Relationship to member

_____ _____
Signature of Authorized Representative **Date**

Address: _____ Telephone Number: _____

_____

_____

* The date of the member's signature must be on or after the denial of the disputed claims, approvals, or authorizations. An electronic signature is not a valid signature.