Appointment of Representative and Authorization to Disclose

Privacy Act Statement

This statement serves to inform you of the purpose for collecting personal information required by Humana Military Automated Information System and how your personal information will be used.

AUTHORITY: 10 U.S.C. Chapter 55, Medical and Dental Care; 10 U.S.C. 1079 Contracts for Medical Care for Spouses and Children: Plans and 1086 Contracts for Health Benefits for Certain Members, Former Members, and Their Dependents; 38 U.S.C. Chapter 17 Hospital, Nursing Home, Domiciliary, and Medical Care; 32 CFR Part 199, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); and E.O. 9397 (SSN), as amended.

PURPOSE: To obtain information from individuals to validate their eligibility as beneficiaries, grant access to the Humana Military website, and provide beneficiary services available through Humana Military to validated individuals, including physician referrals, healthcare authorizations, claims payment, assignment of beneficiaries to physicians, and informational contact with validated beneficiaries.

ROUTINE USES: Information collected may be used and disclosed generally as permitted under 45 CFR Parts 160 and 164, Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules, as implemented by DoD 6025.18-R, the DoD Health Information Privacy Regulation. Information collected from you may also be shared with the Departments of Health and Human Services and Homeland Security, and other Federal, State, local, and foreign government agencies, private business entities under contract with the Department of Defense, and individual providers of care, on matters relating to eligibility, claims pricing and payment, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil or criminal litigation.

DISCLOSURE: Voluntary; however, failure to furnish all requested information will result in an individual not being able to access beneficiary services available through Humana Military.

APPLICABLE SORN: EDHA 07, Military Health Information System (June 15, 2020; 85 FR 36190) https://dpcld.defense.gov/Portals/49/Documents/Privacy/SORNs/DHA/EDHA-07.pdf

Prohibition on redisclosure:

Further disclosure of information by the appointed representative may only be made in accordance with the provisions of the *Privacy Act of 1974, the Health Insurance Portability and Accountability Act of 1996 (HIPAA),* and other applicable Federal law.

Instructions for completing this form:

1. You must insert the name of the person (your spouse or legal guardian, your physician or the facility [hospital, ambulatory surgery center or radiology center]) you are appointing as your representative to act in your behalf of the appeal. This person's or facility's name goes on the top line.
2. Please sign and date and have the appointed person or facility return this form along with the written request for an appeal.

The appeal and Appointment of Representative Form may be sent to:

Mail:
Utilization Management
Humana Military
PO Box 740044
Louisville, KY 40201-7444

Email:
hmhsrecon@humanamilitary.com

Fax:
(877) 850-1046

TRICARE® EAST REGION

I appoint: _____

(name and address of a representative)

to act as my representative in connection with my appeal under *32CFR199.10*, appeal and hearing procedures. In addition, authorize the Defense Health Agency (DHA) to release to said representative, information related to medical treatment, and if necessary, photocopies of any medical records which may be required for adjudication of my claim for tricare benefits to avoid the possibility of a conflict of interest, an officer or employee of the United States such as an employee or member of a uniformed service, including an employee or staff member of a uniformed service legal a military hospital or clinic provider, or a health benefits advisor, is not eligible to serve as a representative. An exception usually is made when an employee or member of a uniformed service is representing an immediate family member. In addition, I authorize the DHA to release to said representative, information related to medical treatment, and if necessary, photocopies of any medical records which may be required for adjudication of my claim for tricare benefits.

I understand the representative shall have the same authority as the part to the appeal and notice given to the representative shall constitute notice to the part. This consent will expire upon the issuance of the final agency decision regarding my appeal, however I reserve the right to withdraw this authorization at anytime.

Beneficiary or guardian signature: _____ Date: _____

Print name: _____ Case ID # _____