APPOINTMENT OF AUTHORIZED REPRESENTATIVE

General Information for Participants/Members

An Authorized Representative is a person that you authorize and appoint to act on your behalf, to **request benefits** or information under your medical plan or to **appeal a medical claim** that was denied in whole or in part. When you designate someone as your Authorized Representative, you are giving that individual and Network Health permission to disclose and discuss your medical information, benefit eligibility and other medical plan details that are reasonably necessary to resolve issues on your behalf.

If you want to appoint an Authorized Representative to act on your behalf, this authorization can be granted in a couple of different ways.

1. If you just need help with **one particular situation**, such as a specific medical claim that was denied in whole or in part, you can appoint an Authorized Representative just to help with this one issue. Sometimes people designate their medical provider or another trusted individual to help with this one situation only.
2. If you want to appoint an Authorized Representative to act on your behalf for **any and all medical plan issues** that may come up under your benefit plan, it may be more appropriate to appoint a family member or other trusted person who you authorize to always act on your behalf.

If you wish to appoint someone to act on your behalf related to your medical plan issues, please complete the following information.

A. Member/Participant's Full Name ____

B. Member/Participant's Identification Number from Medical Plan ID Card

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C. Member/Participant's Phone Number (_____________)___________________________

D. Member/Participant's Address

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I, ________________________________, hereby appoint the following person as my Authorized Representative, to act on my behalf in connection with coverage under the medical plan, prior authorization requirements, filing of benefit claims or appeals:

Name of Your Authorized Representative ____

Authorized Representative's Address and Phone Number

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Check one of the options below to indicate if this authorization just applies to one issue, or if you are designating this person to always act on your behalf related to your medical plan:

☐ This authorization is limited to acting on my behalf **for only the following particular situation:**

(Please describe)

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☐ This authorization applies to **any and all medical plan issues** on my behalf.

By designating the above person as your Authorized Representative, you understand that you are also directing and authorizing Network Health to disclose and release information concerning your eligibility and/or claim status to your Authorized Representative which may include disclosing your personal medical information to the extent minimally necessary to resolve the issue. Network Health is also directed to accept an appeal of a claim from your Authorized Representative, and to keep that Authorized Representative informed of the status of that appeal, including disclosing all required documents to that Authorized Representative on your behalf.

This designation of Authorized Representative can be revoked by you at any time in the future upon written notice to Network Health, however, any information or disclosures that Network Health made to your Authorized Representative prior to receiving your written revocation will be allowed.

If not previously revoked by you, this designation of Authorized Representative will terminate one year from the date you signed this document.

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Print Full Member/Participant Name

____________________________________ ____________________________

Signature of Member/Participant Date Signed

Please return this completed form to:

Network Health
Attn: Appeals and Grievance Department
1570 Midway Pl.
Menasha, WI 54952
Fax: 920-720-1832