APPOINTMENT OF REPRESENTATIVE (AOR) FORM

Name of person you are appointing as an Authorized Representative: _____

Relationship to covered person: Relative Healthcare Provider Attorney Other _____

Contact information of authorized representative

Mailing Address:

Daytime Phone:

Email Address: **Fax:**

Covered Person Information

Name: **ID Number:**

Mailing Address:

Phone:

Email Address: **Fax:**

Appointment of Authorized Representative (Purpose: To grant permission for another individual or company to act on your behalf in filing a Grievance or Appeal). You may revoke this authorization at any time.

I, _____ (Member Name), appoint _____ (Name of Authorized Representative), to act on my behalf in connection with any claim for coverage or benefits identified in this case, including receipt of any approval(s) or authorization(s) that are required

I understand that my withdrawing of this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Signatures:

_____

Signature of Covered Person (or legal representative*) **Date**

***Parent, Guardian, Conservator, Other—please specify**

I, _____ (Name of Authorized Representative),

hereby accept the above appointment. I am a/an _____

(Relationship to Member).

_____

Signature of Authorized Representative **Date**

Designated Legal Representative/Guardian:

If this form is signed by someone other than the member or parent, such as a personal representative, legal representative or guardian on behalf of the member, please submit the following:

A copy of a health care, general or Durable Power of Attorney.

OR

A court order or other documentation that show.imm7Q0.00000912 0 612 792 reWhBT/F2 11.04 Tf1 0 0 1 432.58