## APPOINTMENT OF REPRESENTATIVE (AOR) FORM

**Name of person you are appointing as an Authorized Representative:** ____________________________

**Relationship to covered person:** ☐ **Relative** ☐ **Healthcare Provider**

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**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 shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.**

**SEND THIS FORM AND A COPY OF YOUR NOTICE OF ADVERSE BENEFIT DETERMINATION TO ONE OF THE FOLLOWING:**

**Mailing Address: CareSource, Attn: Member Appeals, P.O. Box 1947, Dayton, OH 45401-1947**

**If you need help with this form, you may call the Member Services department at 1-833-230-2099 (TTY: 711), Monday through Friday, 7 a.m. to 7 pm Eastern Time.**

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