



**Health Advantage**

An Independent Licensee of the Blue Cross and Blue Shield Association

## Designation of Authorized Appeal Representative

Name of Plan Participant \_\_\_\_\_

Identification Number of Plan Participant \_\_\_\_\_

Health Advantage will accept appeals submitted on your behalf by an authorized appeal representative. In order to properly designate someone else to pursue an appeal on your behalf, Health Advantage requires that you and the person you wish to designate as your Authorized Appeal Representative must each sign this form, indicating that both you and the person you designate as your Authorized Appeal Representative agree to the terms and conditions stated in this form. If you or your designated Authorized Appeal Representative do not agree to any statements or terms set forth in this form, do not sign this form.

Once you and your designated Authorized Appeal Representative have each signed this form and returned it to Health Advantage at the address listed below, please understand that you have authorized the following to occur:

1. By signing this form, you give permission for the Authorized Appeal Representative to exercise your appeal rights under the Plan.
2. Your signature on this form also gives the Authorized Appeal Representative access to all of your medical information and claims for health care benefits under the Plan, to the extent that any of them are relevant to your appeal.
3. Your signature on this form authorizes the Plan and any of its representatives, to communicate directly with the Authorized Appeal Representative with regard to your appeal, as well as communicate all related information such as claims, medical records, explanations of benefits, telephone calls, correspondence, your address, telephone numbers, social security number and Plan identification numbers, premium payments or other Plan eligibility data related to the appeal.
4. Upon proper submission of this signed form, Health Advantage, will communicate directly to your Authorized Appeal Representative – rather than to you – the decision regarding your appeal, as well as other information related to the appeal.

If you wish to designate an appeal representative, please complete parts A through D of this form and forward it to Health Advantage at the address shown at the bottom of this form.

### A. IDENTIFICATION OF CLAIMS YOU WISH TO APPEAL

Please list the claims you authorize the Authorized Appeal Representative to appeal for you:

Name of Health Care Provider	Date(s) of Service	Amount You Claim is Owed by Plan
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

NOTE: If all claims will not fit in the spaces provided above, you may submit an additional page, showing the requested details; however, the additional page MUST BE SIGNED AND DATED BY YOU or it will not constitute a valid authorization for the Authorized Appeal Representative to represent you with respect to appeal of any such identified claims.

### B. IDENTIFICATION OF YOUR AUTHORIZED APPEAL REPRESENTATIVE

In the space below, enter the full name of your Authorized Appeal Representative, along with their

address and telephone number.

\_\_\_\_\_  
Name of Authorized Appeal Representative (Please Print)

\_\_\_\_\_  
Address of Authorized Appeal Representative

\_\_\_\_\_  
Telephone Number of Authorized Appeal Representative

C. YOUR SIGNATURE

\_\_\_\_\_  
(Signature of Plan Participant)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Date Signed)

D. SIGNATURE OF AUTHORIZED APPEAL REPRESENTATIVE

The undersigned hereby accepts designation by the above-named Plan Participant to act as Authorized Appeal Representative. The undersigned understands and agrees that any claim for benefits allegedly due under the Plan, whether asserted on behalf of the Plan Participant or asserted by the undersigned on its own behalf as assignee or agent of the Plan Participant, is subject to and governed by the terms and conditions, policies and procedures of the Plan. The undersigned hereby agrees to abide by all terms and conditions of the Plan, including such allowances and payment limitations as the Plan, by its terms, may establish. In accepting this designation, the undersigned hereby represents that it will keep the Plan Participant fully informed on a timely basis of the status of any appeal and of all related communications exchanged with Health Advantage. The undersigned agrees to fully discharge the undersigned's obligations to the Plan Participant in acting as the Plan Participant's agent with respect to any appeal. Should the Plan Participant at any time indicate to the undersigned a desire to revoke this designation, the undersigned agrees to immediately cease acting on behalf of the Plan Participant, and to provide prompt, written notice of the same to Health Advantage.

\_\_\_\_\_  
Signature of Authorized Appeal Representative

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date Signed

Please return this signed form to:  
HMO Partners, Inc. d/b/a Health Advantage  
Attn. Member Response Coordinator  
P.O. Box 8069  
Little Rock, AR 72203-8069  
Facsimile: 501-212-8518