HEALTH TRADITION HEALTH PLAN

P.O. Box 188 La Crosse, WI 54602-0188
1-608-781-9692 1-888-459-3020 FAX 1-608-781-9653

AUTHORIZATION FOR REPRESENTATIVE TO ACT ON MY BEHALF IN APPEALS AND GRIEVANCES

I hereby authorize

Name:_____
(May be name of a person or a provider organization)

Relationship:_____

Address:_____

City, State, Zip:_____

Phone:_____

to act as my Authorized Representative for the purpose of representing me in the appeals and grievance process with Health Tradition Health Plan.

I understand that this authorization does not allow disclosure of medical information to the representative unless a separate Release of Medical Information form is signed. I understand appeals and grievances will be processed regardless of whether Medical Information is released.

You may make a choice of who receives the written communications as the appeals process proceeds. Please specify:

- ☐ My Authorized Representative will be the only one to receive all notices and communications, including the outcome and any future rights regarding any appeals.
- ☐ Please send notices and communications, including the outcome and any future rights, to **both** my Authorized Representative and myself.
- ☐ Please send notices and communications, including the outcome and any future rights, to only myself and **not** to my Authorized Representative.
- ☐ Other instructions:_____

_____

I also understand that this authorization is revocable. Unless revoked, it will expire 180 days from the Date of signature._____/_____/_____ Date of Expiration _____/_____/_____

Member Name (print)_____

Date of Birth _____/_____/_____

Member Address _____

Insurance ID #: _____ Insurance Plan:_____

Member Signature_____

Exemptions

The member may not need to provide authorization in writing if certain exemptions apply.
Please specify below if you believe the member does not need to designate anyone in writing:

- ☐ The above named person is authorized by law to act on the member's behalf. Legal documentation will be required to proceed in the appeal process.
- ☐ The member is unable to give consent and the above named person is a spouse or family member.
- ☐ This is an expedited appeal and I represent that the member has verbally given authorization for me to represent them.
- ☐ The member is unable to give consent and the above named person is a treating provider.

I attest that one of the above exemptions applies and the named Authorized Representative is to act as designated on this form.

Signature (please print, then sign)_____

Relationship to member_____

Date_____/_____/_____