MEDICAL MUTUAL®

Designation of Authorized Representative for Appeals or to Request Information

This form is only for appointing an authorized representative to act on your behalf in requesting information, generally in the case of a denied claim or service, requesting appeals and/or during appeals. It does NOT constitute, in and of itself, a request for an appeal. This form should be submitted along with a request for an appeal if you are represented by a third party.

Reset Fields

Background

I understand and agree that by executing this Designation of Authorized Representative, I authorize Medical Mutual, its administrators, agents, and other third party service providers to discuss and disclose the individually identifiable health information described below to the person designated below as my authorized representative to the same extent that such information may be discussed with, and disclosed to, me. I understand that individually identifiable health information:

(i) either identifies me or reasonably may be used to identify me; and
(ii) includes information regarding my physical or mental condition, my healthcare and/or payment for my healthcare.

I have read this Designation of Authorized Representative carefully, including the Section labeled "Important Information About My Rights." I hereby voluntarily execute this Designation of Authorized Representative with the intent that it be valid and legally binding under applicable state law and the HIPAA Privacy Regulations

Designation – Please complete all sections of this form.

Patient Information

Last Name	First Name	Middle Initial

Address

Phone Number	Date of Birth	Member ID Number	Group Number

Authorized Representative Information

Name	Relationship

Address

Phone	Fax	

Description of Denied Claim or Services Being Appealed or about which Information is Being Requested

Claim Number; and/or	Date of Service; and/or	Provider; and/or	Other

Appointment

By signing this form, I hereby appoint the Authorized Representative named above as my Authorized Representative to act on my behalf in filing appeals related to the Denied Claim or Services Being Appealed, or in requesting information, described above. If an appeal is being made, this Authorized Representative is authorized to file the following types of appeals related to the Denied Claim or Services Being Appealed specified above:

- ☐ Internal Appeals with Medical Mutual or Plan
- ☐ External Review (if External Review is available)
- ☐ All levels of internal appeal and external review available for this claim

Unless otherwise specified below, notices and communications concerning requests for information or appeals, including the outcome and any future rights, will be sent to both my Authorized Representative and me. Please specify if other:

Other

I understand that this authorization does not provide my Authorized Representative with any authority, either implied or direct, over any treatment or direct care decisions. I understand and agree that this authorization does not provide my Authorized Representative with any rights under my health plan other than to pursue the indicated appeals on my behalf or to obtain requested information on my behalf. I understand and agree that this authorization does not entitle the Authorized Representative to receive any payments relating to the Denied Claim or Services Being Appealed as described above and that any such payments will be made in accordance with the terms of my healthcare plan.

Authorized Use and/or Disclosure of Personal Health Information

I understand and agree that this appointment authorizes Medical Mutual to disclose to, release to, and discuss with my Authorized Representative all information concerning the Denied Claim or Service Being Appealed or about which information is being requested as specified above, including, but not limited to, claim status, eligibility and medical records and other individually identifiable health information, for the purpose of assisting with a claim or filing an appeal on my behalf.

I understand and agree that Medical Mutual will be held harmless from any disclosure or use of my personal health information that may be made by my Authorized Representative.

I understand and acknowledge that this authorization extends to all medical records related to the Denied Claim or Services Being Appealed or about which information is being requested as specified above and as determined by Medical Mutual, including any records which contain information regarding treatment for physical and mental illness, alcohol/drug abuse and/or HIV – AIDS test results or diagnosis. I expressly consent to the release of such information.

Limitations on Disclosure:

I understand that I have the right to limit the information that Medical Mutual releases under this authorization. For example, I may limit my Authorized Representative's access to information about a particular healthcare provider or a particular diagnosis/disease. Any such limitations must be described below in writing. I understand that by leaving this section blank, I am creating no limitations on disclosure.

Limitations on disclosure

Expiration

This appointment of my Authorized Representative and authorization to release information to my Authorized Representative will automatically expire upon completion of the appeal and external review (if applicable) process for the Denied Claim or Services Being Appealed specified above or one (1) year from date of signature, whichever occurs first.

Important Information About My Rights

- This appointment of Authorized Representative is voluntary and I may revoke it at any time by submitting a written revocation to the Medical Mutual, Member Appeals Department at the address listed on page 3 of this form.

  The revocation will not have any effect on any actions taken or information provided before receipt and/or notice of the revocation.

- I am entitled to a signed copy of this Designation of Authorized Representative.
- Medical treatment, payment, enrollment in or eligibility for benefits under a healthcare plan will not be conditioned upon my signing this Designation of Authorized Representative.
- I understand that the individually identifiable health information may be re-disclosed by my Authorized Representative. Once individually identifiable information is in the possession or control of my Authorized Representative, it will no longer be subject to the restrictions on uses and disclosure imposed under the HIPAA Privacy Regulations. I understand and agree that Medical Mutual will be held harmless from any disclosure or use of my personal health information that may be made by my Authorized Representative.

I understand that, if I do not wish the person named above to remain my Authorized Representative, I must revoke this appointment and authorization by giving signed written notice to Medical Mutual, Member Appeals Department at the address listed on page 3 of this form. I understand that my revocation of this appointment and authorization will not affect any action Medical Mutual has taken, or any information that Medical Mutual may have already released, based upon this appointment and authorization before Medical Mutual actually received my request to revoke this appointment and authorization. Medical Mutual will be held harmless for any action taken based on this appointment and authorization prior to being notified of the revocation.

Signature

I agree a photocopy or facsimile copy of this authorization shall be accepted with the same authority as the original.

I have read this Authorized Representative Form. I understand that, by signing this form, I am confirming my appointment of the Authorized Representative named above and my authorization that Medical Mutual use and/or disclose my personal health information to my Authorized Representative for the purpose described above.

Signature	Date

Printed Name

If you are acting on behalf of the above named member as a legal representative, please provide the appropriate legal documentation (example: Power of Attorney).

Send completed and signed form to:	Or fax to:
Medical Mutual Member Appeals P.O. Box 94580 Cleveland, Ohio 44101-4580	(216) 687-7990 (866) 691-8260

AUTHORIZED REPRESENTATIVE'S ACKNOWLEDGEMENT OF TERMS OF AUTHORIZATION

As the designated Authorized Representative identified above, I hereby acknowledge having read and understood this Authorization and, by undertaking to act as the Authorized Representative as expressed above, I hereby acknowledge and agree to the terms and conditions of this Authorization.

Authorized Signature	Date

Authorized Representative Printed Name