



Member's Voluntary Assignment of Health Care Designee/Release of Protected Health Information Form for Appeals

Section A: Member Information.

I do hereby swear that I am the enrollee or have the legal authority to appoint a Health Care Designee on behalf of the enrollee. I do hereby appoint the individual listed in Section B to act as the enrollee's Health Care Designee and hereby authorize Mercy Health Plans, Inc. to release protected health information as described below. I understand that this authorization is voluntary. I understand that federal and state privacy laws may not pertain to the organization or individual I am authorizing to receive protected health information.

Section B:

The following organization/individual(s) is/are authorized to act as my Health Care Designee and may submit an appeal on my behalf, receive or use Protected Health Information pertaining to my Appeal only:

Member Name:
Medicare/HIC Number:
Address: _____
City _____ State _____ Zip _____
Telephone #:

Name:
Relationship to Member:
Address: _____
City _____ State _____ Zip _____
Telephone #:

Section C: I understand that:

- This authorization is voluntary.
- I may revoke this authorization at any time by notifying Mercy Health Plans, Inc. in writing. If this authorization is revoked, it will not have any effect on any actions taken prior to the receipt of the revocation.
- I would like this authorization to expire on (enter date) ___/___/___.

(If no expiration date is provided, this authorization will expire 1 year from the date of issue or until I notify Mercy Health Plans, Inc. in writing that I revoke this authorization.)

- Payment, enrollment or eligibility for benefits for my health care will not be affected if I do not sign this authorization.
- Information disclosed as a result of this authorization may no longer be protected by federal or state privacy laws and may be disclosed by the organization or individual receiving my protected health information.
- I should retain a copy of this authorization form.

Signed: _____
(Signature of individual, parent on behalf of minor, or Personal Representative)

Print Name: _____

Date: _____/_____/_____

Section D: Acceptance of Appointment

Member Name has authorized Designee to act as his/her Health Care Designee. Designee may, therefore, submit an appeal on Member's Name behalf, receive or use Protected Health Information pertaining to the Appeal only.

I accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration or the Centers for Medicare & Medicaid Services; that I am not, as a current or former officer or employee of the United States, disqualified from acting as the claimant's representative; and that I will not charge or received any for the representation unless it has been authorized in accordance with the laws and regulations of the Social Security Act. In the event that I decide not to charge or collect a fee for the representation I will notify the Social Security Administration and the Centers for Medicare & Medicaid Services (completion of Section E satisfies this requirement).

Signed: _____
(*Signature of Representative*)

Print Name: _____

Date: ___/___/___

Section E: Waiver of Fee or Direct Payment

(Note to representative: You may use this portion of the form to waive a fee or to waive direct payment of the fee from withheld past-due benefits.)

I waive my right to charge and collect a fee for representing _____ before the Social Security Administration or the Centers for Medicare & Medicaid Services.

Signature: _____

Print Name: _____

Date: ___/___/___