Print Form

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Authorized Representative Form

Use this form to authorize an individual to file an internal UHA appeal and communicate on your behalf with UHA on a one-time basis regarding the specific appeal. For your convenience, some fields may be pre-filled. If they are not accurate, please correct them.

Please return the completed form to the Appeals Coordinator at the address below, and *keep a copy for your records.*

Member Name _____ **Phone Number** _____

Address _____ **Member Number** _____

Name and address of the authorized representative that will appeal on your behalf

Name: _____ Address: _____

Relationship to Member: _____ _____

Your authorized representative will have access to all medical information of any sort relevant to the appeal as described in Section 9: If you Disagree with our Decision in your Medical Benefits Guide.

☐ Check here if you authorize UHA to give out information related to any of the following, should it be contained within the medical record that applies to your appeal:

- HIV, AIDS, or AIDS-related complex diagnosis or treatment
- alcohol or drug use, diagnosis, or treatment
- mental health counseling, diagnosis, or treatment

Reason for appointing an authorized representative

To conduct an internal UHA appeal review of an adverse determination made by UHA, pursuant to my request.

Date(s) of service:

Description of service(s):

Right to take back ("revoke")

- I may revoke this authorization at any time by giving written notice to UHA at the address below. I understand my revocation will NOT affect any appeal request that occurred before UHA received notice of my written revocation and there may be other legal restrictions on my ability to revoke this authorization.
- If I do not revoke it, this authorization will expire one year from the date of signature below

I authorize UHA to allow my authorized representative to act on my behalf as described above. This authorization is voluntary. I understand that UHA will not condition my treatment, payment, enrollment, or eligibility for benefits on the signing of this authorization except as allowed by law. I understand my protected health information may be re-disclosed by the recipient(s) without my permission and may no longer be protected by law.

Sign Your Name _____ Date _____

If you are not the UHA member listed above you are signing as a personal representative. Please provide the following:

- Attach the appropriate documentation (for example, Medical Power of Attorney, or court order)
- Your phone number: _____