# Instructions for completing the Designation of Representative/Authorization Form



This form is to be used for a grievance or an appeal and to allow a party to act as the Authorized Representative in carrying out a grievance or an appeal.

If you have any questions, please feel free to call us at the customer service number on your member identification card. Please read the following for help completing page one of the form.

#### Part A: Member information

This section applies to the member who is asking for the release of his or her information to another person or company or a request to appoint an Authorized Representative. Please include as much information as you can.

- Print your last name, first name, and middle initial.
- Write your date of birth in this format: mmddyyyy. (If you were born on October 5, 1960, you would write 10051960.)
- Write your full street address, city, state, and ZIP code.
- Write your daytime phone number (including area code.)
- Write your cell/mobile number (including area code.)
- Identification number You will find this number on your member identification card.
- Group number

You will find this number on your member identification card. If your identification card does not have a group number leave this blank.

## Part B: Person or company who can receive this information

- Oheck the box that applies to you. Write the full name of the person or company that you want us to give your information to. Please don't use a general term like "my daughter" or "my son" as it will not be accepted. You need to be specific.
- If you check "Other," give the first and last name (if available), the name of the company (if applicable), and how they relate to you.

#### Part C: Information that can be released

This section tells us what information you would like us to release: all or just some.

- For "all of your information," check the first box (this does not include sensitive information.)
- For "limited information," check the second box and the boxes that apply to you.
- Some topics may be very personal or sensitive to you. If you wish to approve the release of this type of information, check the box(es) that apply to you.

| This form is to be used for a g<br>Representative in carrying out<br>release an individual's health ir<br>(If an individual wants to desig<br>Authorization form.)  | a grievance or ar<br>oformation to and   | n appèal. This<br>other person c   | form is to be filled out by an<br>or company. Please include a   | individual<br>s much in  | if there is a request to formation as you can.   |  |  |  |
|---|--|--|--|--|--|--|--|--|
| Part A: Member information  |  |  |  |  |  |  |  |  |
| Member last name  |  | Member first name  |  | Middle<br>initial  | Member date of birth<br>(MMDDYYYY)   |  |  |  |
| Member street address   | lember street address  |  | City   |  | ZIP code   |  |  |  |
| Daytime phone number (with area code)   | Cell/mobile pho<br>(with area code   | ne number  | Identification number (see identification card)  | Group number (see identification card)   |  |  |  |  |
| Part B: Person or company w   | ho will receive  | this informati   | on   |  |  |  |  |  |
| The following people or comp<br>Please enter first and last name  |  |  |  |  |  |  |  |  |
| My spouse (enter first and las  | , ,  |  | My parents (if you are over  |  |  |  |  |  |
| My domestic partner (enter first and last name)   |  |  | My insurance broker or ag<br>company and first and las   | nsurance broker or agent (enter the name of the boary and first and last name, if you have it) |  |  |  |  |
| My adult children (enter first  | )  | Other (enter first and last name ,if you have it, name of company, and how it's related to you)  |  |  |  |  |  |  |
| Part C: Information that can  | be released  |  |  |  |  |  |  |  |
| I allow the following informat Check only one box.  All my information. The healthcare providers and (see below) unless it is a OR  | s can include he financial informa   | alth, a diagno:  |  | ion), clain  | ns, doctors and other  |  |  |  |
| Only limited informati  |  |  | boxes below that apply to you  | ı).  |  |  |  |  |
| ☐ Appeal ☐ Benefits and covera ☐ Billing ☐ Claims and paymen  | ge □ Finano<br>□ Medio<br>t □ Pre-ce   | al records<br>ertification and   | d pre-authorization  | Referral<br>Freatment<br>Dental<br>Vision  |  |  |  |  |
| □ Doctor and hospital □ Diagnosis (name of  |  | eatment appro  |  | Pharmacy   |  |  |  |  |
| I also approve the release of t   | he following type  | , .  | , ,  | ck all box   | es that apply to you):   |  |  |  |
| OR<br>☐ Just sensitive informa  | tion about topic   | cs checked b   | elow   |  |  |  |  |  |
| ☐ Abuse (sexual/phys<br>☐ Substance use diso<br>☐ Genetic testing   | rder 1,2   | 1 HIV or AIDS<br>1 Mental health<br>1 Sexually tran  | □ Repro  | ductive he<br>ling aborti  | alth <sup>3</sup><br>on, maternity, etc.)  |  |  |  |
| <ol> <li>Specify time period of record<br/>Description of records that </li> </ol>  |  |  |  |  |  |  |  |  |
| 2 Unless I specify otherwise of by Anthem about me. I under confidentiality laws and reguin the laws and regulations. Part E. I understand that I can be a specific to the laws and regulations. The laws and regulations are specifically as the laws and regulations. | on this form, I into<br>erstand that my s<br>ulations and cann<br>I also understand<br>annot cancel this<br>s, but it not limite | end this discloubstance use ot be disclosed that I may reapproval when the disclosed to, both maintenance in the control of th | disorder records are protecte<br>d without my written consen<br>voke (or cancel) this approval<br>n this form has already been | d under Fe<br>t unless of<br>at any tim<br>used to dis<br>nitv. pregr                          | ederal and State<br>therwise provided for<br>ne, or as described in<br>sclose information.<br>nancy loss, miscarriage, |  |  |  |

#### Please read the following for help completing page two of the form.

# Part D: Person or company who can act as my authorized representative

This section tells us who you have given the right to act as your Authorized Representative in carrying out a grievance or appeal. Part B and C must also be completed to authorize the release of your information.

- Check the box that applies to you. Write the full name of the person or company that you want to act as your Authorized Representative. Please don't use a general term like "my daughter" or "my son" as it will not be accepted. You need to be specific.
- If you check "Other", give the first and last name (if available), the name of the company (if applicable, and how they relate to you.

#### Part E: Date your approval expires

You have two choices of when you would like this approval to end.

- Oheck the first box for the conclusion of the grievance or appeal process.
- Check the second box for an earlier date (please provide details.)

#### Part F: Purpose of this approval

This section tells us the reason you've asked for the release of your information.

- Oheck the first box to let us know who to give out this information as shown on this form.
- 6 Check the second box to let us know what information to give out (identified in Part C.)

#### Part G: Review and approval

- Sign your name and put the date on the form. Your name and signature must match the information in Part A.
- If you are signing this form on behalf of another person, or if you have Power of Attorney for healthcare, or are a legal guardian/conservator you must do the following:
  - You must complete the Designated Legal Representative/Guardian section.
  - You must also provide us with a copy of the legal document showing that you are approved and include it with this form.

| The following person or company has the right to a person who you appoint to be your representar rights that may be available to you. They must be authorize the release of your information to your Please check each box that applies and enter first  | tive in carr<br>e 18 years<br>Authorize  | rying out a grievance o<br>s of age or older. Please<br>ed Representative.   | ntative. An Author<br>r appeal, includin<br>e also complete F  | ized R<br>g any<br>art B   | exte<br>and  | esentative is<br>ernal review<br>C above to   |  |  |
|--|--|--|--|--|--|---|--|--|
| My spouse (enter first and last name)  |  | My parents (if you   | are over 18 — en   | er firs  | t and  | d last name[s]  |  |  |
| My domestic partner (enter first and last name)  |  | My insurance broke company and first   | roker or agent (enter the name of the<br>rst and last name, if you have it)  |  |  |   |  |  |
| My adult children (enter first and last name[s])   |  | Other (enter first ar company, and how   | r first and last name ,if you have it, name of and how it's related to you)  |  |  |   |  |  |
| Part E: Date your approval expires   |  |  |  |  |  |   |  |  |
| If this document was not already withdrawn, this  ☐ At the conclusion of the grievance or appeals  ☐ One year from the signature date in Part G.   | approval<br>process.   | will end on the earliest <b>OR</b>   | of the following   | dates:   |  |   |  |  |
| Part F: Purpose of this approval   |  |  |  |  |  |   |  |  |
| <ul> <li>□ To allow an individual to act as my Authorized<br/>external review rights that may be available to</li> <li>□ To disclose information at my request.</li> </ul>   |  | tative in carrying out a   | grievance or appe  | eal, inc   | ludi   | ng any  |  |  |
| Part G: Review and approval  |  |  |  |  |  |   |  |  |
| I have read the contents of this form. I understar as I have stated above. I also understand that sign of require that I sign this form in order for me to be added.   | ning this  | form is of my own free   | will. I understan  | d that   | Anth   | nem does  |  |  |
| as I have stated above. I also understand that signot require that I sign this form in order for me to for benefits.  I have the right to withdraw this approval at any that my withdrawing this approval will not affect released may be given out by the person or grouthe HIPAA Privacy Rule. I am entitled to a copy of the HIPAA Privacy Rule. I am entitled to a copy of the HIPAA Privacy Rule. I am entitled to a copy of the HIPAA Privacy Rule.  | gning this<br>o receive to<br>time by g<br>any action<br>p who reconfithis form  | form is of my own free<br>treatment or payment,<br>giving written notice of<br>n taken before I do so.<br>ceives it. If this happens<br>n.   | e will. I understan<br>or for enrollment<br>my withdrawal t<br>I also understand                                       | d that<br>or be<br>o Anth<br>I that i<br>er be p   | Anthing of the control of the contro | nem does<br>eligible<br>. I understand<br>mation that's<br>ccted under                              |  |  |
| as I have stated above. I also understand that sig<br>not require that I sign this form in order for me to<br>for benefits.  I have the right to withdraw this approval at any<br>that my withdrawing this approval will not affect<br>released may be given out by the person or grou-  | gning this<br>o receive to<br>time by g<br>any action<br>p who reconfithis form  | form is of my own free<br>treatment or payment,<br>giving written notice of<br>n taken before I do so.<br>ceives it. If this happens<br>n.   | e will. I understan<br>or for enrollment<br>my withdrawal t<br>I also understand                                       | d that<br>or be<br>o Anth<br>I that i<br>er be p   | Anthing of the control of the contro | nem does<br>eligible<br>. I understand<br>mation that's   |  |  |
| as I have stated above. I also understand that sig<br>not require that I sign this form in order for me t<br>for benefits.<br>I have the right to withdraw this approval at any<br>that my withdrawing this approval will not affect<br>released may be given out by the person or gru<br>the HIPAA Privacy Rule. I am entitled to a copy of<br>Member signature or Designated Legal Represen  | gning this o receive to time by go any action up who recoff this forn tative/Gual  | form is of my own free<br>treatment or payment,<br>giving written notice of<br>n taken before I do so,<br>seives it. If this happens<br>n.<br>rdian signature  | e will. I understan<br>or for enrollment<br>my withdrawal t<br>I also understand<br>s, it may no longo                 | d that<br>or be<br>o Anth<br>I that i<br>er be p   | Anthing of the control of the contro | nem does<br>eligible<br>. I understand<br>mation that's<br>ccted under                              |  |  |
| as I have stated above. I also understand that sig not require that I sign this form in order for me if for benefits.  I have the right to withdraw this approval at any that my withdrawing this approval will not affect released may be given out by the person or grounder HIPAA Privacy Rule. I am entitled to a copy of Member signature or Designated Legal Represent X  Designated Legal Representative/Guardian—Complete this section only if you have documer if this form is signed by someone other than the or guardian on behalf of the member, please sub   | rtime by g<br>any action<br>p who rec<br>of this forn<br>tative/Gua<br>tation sup<br>member o<br>mit the fo                                | form is of my own free treatment or payment, giving written notice of n taken before I do so. seives it. If this happen: n. rdian signature   poporting Legal Repres or parent, such as a pe llowing:                              | e will. I understan<br>or for enrollment<br>my withdrawal t<br>I also understand<br>s, it may no longo<br>entation.    | d that<br>or be<br>o Anth<br>I that i<br>er be p   | Anthing enternance (M  | nem does<br>eligible  I understand<br>mation that's<br>coted under  MDDYYYY)                        |  |  |
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| as I have stated above. I also understand that sig not require that I sign this form in order for me I for benefits.  I have the right to withdraw this approval at any that my withdrawing this approval will not affect released may be given out by the person or grounder HIPAA Privacy Rule. I am entitled to a copy of Member signature or Designated Legal Represent X  Designated Legal Representative/Guardian—Complete this section only if you have documer If this form is signed by someone other than the or guardian on behalf of the member, please subsection on the complete that the order or other documentation that show representative to act on the member's behalf.   | r time by g<br>any action<br>p who rec<br>of this forn<br>tative/Gua<br>tation sup<br>member o<br>mit the fo                               | form is of my own free treatment or payment or payment or payment on taken before I do so. seives it. If this happens n. rdian signature   pporting Legal Repres or parent, such as a pellowing: ney. OR                           | will. I understan or for enrollment in y withdrawal t I also understant s, it may no longe                             | d that or be o Anth I that i er be p   | Anthing enem.  nem.  nfor  orote  (M)  | nem does eligible I understand mation that's cted under MDDYYYY) representative                     |  |  |
| as I have stated above. I also understand that sig not require that I sign this form in order for me if for benefits.  I have the right to withdraw this approval at any that my withdrawing this approval will not affect released may be given out by the person or grouther HIPAA Privacy Rule. I am entitled to a copy of Member signature or Designated Legal Represen X  Designated Legal Representative/Guardian—Complete this section only if you have document if this form is signed by someone other than the or guardian on behalf of the member, please suit.  A copy of a healthcare, general or Durable Pow.  A court order or other documentation that shor representative to act on the member's behalf. Please complete the following:   | ning this or eceive to receive the time by grany action by the power of this form tative/Guar member or with the form of Attorn we custody | form is of my own free treatment or payment or payment or payment on taken before I do so. seives it. If this happens n. rdian signature   pporting Legal Repres or parent, such as a pellowing: ney. OR                           | will. I understan or for enrollment in y withdrawal t I also understant s, it may no longe entation. rsonal representa | d that or be o Anth I that i t | Anthing enter in the control of the  | nem does eligible I understand mation that's cted under MDDYYYY) representative                     |  |  |
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#### **Examples of legal documents:**

- Health Care, General or Durable Power of Attorney. This document gives someone you trust the legal power to act on your behalf and make health care decisions for you.
- **Legal Guardianship.** This is when the court appoints someone to care for another person.
- Conservatorship. This happens when a judge appoints a responsible person to make decisions for someone who can't make responsible decisions for him/herself.
- **Executor of estate.** This type of document would be used when the person who is being represented has died.

### **Designation of Representative/Authorization Form**



This form is to be used for a grievance or an appeal (see Section D) and to allow a party to act as the Authorized Representative in carrying out a grievance or an appeal. This form is to be filled out by an individual if there is a request to release an individual's health information to another person or company. Please include as much information as you can. (If an individual wants to designate an Authorized Representative not related to a grievance and appeal, use the Member Authorization form.)

| Authorization form.)  |  | •   | 3  |   | ''   | ,   |  |  |
|---|--|---|--|---|--|---|--|--|
| Part A: Member information  |  |   |  |   |  |   |  |  |
| Member last name  Member street address   |  | Member first name  City   |  |   | liddle<br>itial  | Member date of birth (MMDDYYYY)  ZIP code   |  |  |
|   |  |   |  | S   | tate   |   |  |  |
| Daytime phone number (with area code)  Cell/mobile photo (with area code)   |  | ldentification number (see identification card)                                 |  |   | Group<br>(see ic                                       | number<br>dentification card)   |  |  |
| Part B: Person or company w   | ho will receive  | this informatio   | on   |   |  |   |  |  |
| The following people or comp<br>Please enter first and last nam   | anies have the ri<br>ne. By entering fi  | ight to receive i<br>irst/last name b   | my information. They<br>below, that person ma  | must be 1<br>y receive  | 8 years<br>my info                                     | s of age or older.<br>rmation.  |  |  |
| My spouse (enter first and last name)   |  |   | My parents (if you are over 18 — enter first and last name[s])   |   |  |   |  |  |
| My domestic partner (enter first and last name)   |  |   | My insurance broker or agent (enter the name of the company and first and last name, if you have it)                             |   |  |   |  |  |
| My adult children (enter first and last name[s])  |  |   | Other (enter first and last name ,if you have it, name of company, and how it's related to you)                                  |   |  |   |  |  |
| Part C: Information that can I  | e released   |   |  |   |  |   |  |  |
| I allow the following informati Check only one box.  All my information. Thi healthcare providers and (see below) unless it is ap OR Only limited information Appeal Benefits and coverage Billing  | s can include he financial information operated below.  on may be released to the control of the | ealth, a diagnos<br>ation (like billin<br>sed (check all b<br>ility and enrollr | is (name of illness or<br>g and banking). This o<br>oxes below that apply  | condition<br>doesn't in<br>to you).<br>Refe                     | ), claim<br>clude s<br>erral<br>atment                 | ns, doctors and other   |  |  |
| ☐ Claims and payment ☐ Pre-certification and ☐ Doctor and hospital (for treatment appro☐ Diagnosis (name of illness or condition) and proce   |  |   | d pre-authorization □ Vision<br>ovals) □ Pharmacy  |   |  |   |  |  |
|   |  |   |  | m (ahaak  | all bay  | as that apply to you'   |  |  |
| I also approve the release of t  ☐ All sensitive information  OR  ☐ Just sensitive information  | on <sup>2</sup>  |   | ,  | m (cneck  | ali boxe   | es that apply to you):  |  |  |
| ☐ Abuse (sexual/physi☐ Substance use disor☐ Genetic testing  1 Specify time period of record Description of records that records the records the records that records the recor | cal/mental)<br>der <sup>1,2</sup><br>ds to be disclose   | ☐ HIV or AIDS<br>☐ Mental health<br>☐ Sexually transed:                         | smitted illness  | `   | j aborti   | alth <sup>3</sup><br>on, maternity, etc.)   |  |  |
| 2 Unless I specify otherwise o by Anthem about me. I unde confidentiality laws and regulations. I Part E. I understand that I ca  | n this form Lint   | end this disclo   | sure to include all sub<br>lisorder records are po<br>d without my written c<br>oke (or cancel) this ap<br>this form has already | stance us<br>rotected u<br>consent ur<br>oproval at<br>been use | e disord<br>nder Fe<br>nless ot<br>any tim<br>d to dis | der records maintained deral and State herwise provided for e, or as described in sclose information. |  |  |

3 Reproductive health includes, but it not limited to, both male and female infertility, maternity, pregnancy loss, miscarriage, family planning, birth control, both elective and spontaneous abortion, and any other related care or services.

### Part D: Person or company who can act as my authorized representative The following person or company has the right to act as my Authorized Representative. An Authorized Representative is a person who you appoint to be your representative in carrying out a grievance or appeal, including any external review rights that may be available to you. They must be 18 years of age or older. Please also complete Part B and C above to authorize the release of your information to your Authorized Representative. Please check each box that applies and enter first and last name. My spouse (enter first and last name) My parents (if you are over 18 — enter first and last name[s]) My domestic partner (enter first and last name) My insurance broker or agent (enter the name of the company and first and last name, if you have it) Other (enter first and last name, if you have it, name of My adult children (enter first and last name[s]) company, and how it's related to you) Part E: Date your approval expires If this document was not already withdrawn, this approval will end on the earliest of the following dates: ☐ At the conclusion of the grievance or appeals process. ☐ One year from the signature date in Part G. Part F: Purpose of this approval ☐ To allow an individual to act as my Authorized Representative in carrying out a grievance or appeal, including any external review rights that may be available to me. ☐ To disclose information at my request. Part G: Review and approval I have read the contents of this form. I understand, agree, and allow Anthem to the use and release of my information as I have stated above. I also understand that signing this form is of my own free will. I understand that Anthem does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible I have the right to withdraw this approval at any time by giving written notice of my withdrawal to Anthem. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form. Member signature or Designated Legal Representative/Guardian signature Date (MMDDYYYY) Designated Legal Representative/Guardian — Complete this section only if you have documentation supporting Legal Representation. If this form is signed by someone other than the member or parent, such as a personal representative, legal representative or guardian on behalf of the member, please submit the following: A copy of a healthcare, general or Durable Power of Attorney. **OR** A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf. Please complete the following:

City

# Signature

Legal representative street address

Legal representative (print full name)

### Please return the completed form to:

Anthem Blue Cross and Blue Shield

Legal relationship to member

State ZIP code

Date (MMDDYYYY)