

## FEDERAL EMPLOYEE PROGRAM DESIGNATION OF REPRESENTATIVE AS AUTHORIZED REPRESENTATIVE FOR THE DISPUTED CLAIMS PROCESS

Name of the Blue Cross and Blue Shield Service Benefit Plan member:
Name of many and spiration and relationship to Comice Description and a
Name of person granting authorization and relationship to Service Benefit Plan member (if other
than the member) (e.g., parent, personal representative):
I decignate the following representative
I designate the following representative (insert name of doctor, hospital division, laboratory, health plan or other entity) as my authorized representative to appeal the claims decision listed below:
This authorization is for the sole purpose of allowing me, as the member, or my named personal representative to dispute the items noted below, and expires upon completion of the disputed claims process:
Pre-Service Reference #
Claim #
Refund Request Document #
Other



As necessary for this appeal, I authorize the use and disclosure of my protected health information<sup>1</sup> as follows:

I authorize the Blue Cross and Blue Shield Federal Employee Program (FEP) to release protected health information including all medical records, medical rationale, or relevant reference materials

FEP used in making their benefit denial decision to my authorized representative. The authorized individual(s) or organization(s) I select to receive this information are:			
(Insert the name of the person(s) or organization(s) autinformation.)	thorized <u>to receive</u> your protected he	alth	
I do not wish to have the following protected health infor	rmation disclosed:		
(Describe in <u>as much detail as possible</u> the protected health or disclosed. For example, the information to be used or disclaims. You should include, if available, the types of claims, a	closed may relate to payment, enrollment		
I understand that I may withdraw this authorization at at to FEP Member Services at 1310 G. Street, N.W. Wash will be effective for future uses and disclosures of profurther understand that this withdrawal will not be effective Plan already has used or disclosed, relying on this	ny time by sending a written notificat nington, D.C. 20005 and this withdray otected health information. Howeve fective for information that the Serv	wal er, I	
Signature of Member or Personal Representative	Date		
Name of Provider Pursuing Internal Appeal If a covered entity is requesting this Authorization, the a signed copy of this document.	covered entity must provide the mem	ber	

<sup>&</sup>lt;sup>1</sup>Protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a healthcare provider, a health plan, my employer, or a healthcare clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of healthcare to me.