Humana

Grievance and Appeal Department

APPOINTMENT OF AUTHORIZED REPRESENTATIVE FORM

Member Name _____ **Member ID Number** (to be completed by member) _____

I, _____ (Name of Member), appoint Stephanie Stuart (Name of Authorized Representative)

to act on behalf of _____ (Name of Member)

in connection with any claim for coverage or benefits identified in case # _____ including receipt of any approval(s) or authorization(s) that are required before medical service(s). I authorize my representative to receive any, and all information related to this case that is provided to me, and to act for me and for my minor dependent, if named above, in providing any information to the group health plan in relation to the disputed claims, approvals, or authorizations. This document is not intended to authorize access to any personal health information unrelated to the disputed claims, approvals, or authorizations.

Signature of Member* _____ **Date*** _____

Address: _____ Telephone Number: _____

I, Stephanie Stuart (Name of Authorized Representative), hereby accept the above appointment.

I am a/an A/R Analyst (Relationship to member)

Signature of Authorized Representative _____ **Date** _____

Address: Raleigh Sedation Associates LLC Telephone Number: 919-324-1680

P O Box 865619

Orlando, FL 32886-5619

* The date of the member's signature must be on or after the denial of the disputed claims, approvals, or authorizations. An electronic signature is not a valid signature.