UHC Appeals - UMR
Appeals Coordinator
P.O. Box 400046
San Antonio, TX 78229

APPEALS - DESIGNATION OF AUTHORIZED REPRESENTATIVE

I, _____, do hereby appoint, _____ (hereinafter "my Authorized Representative") to act on my behalf in pursuing a benefit claim, specifically, my claim(s) for (Pre-Service Case number). My Authorized representative shall have full authority to act, and receive notices, on my behalf with respect to an initial determination of the claim, any request for documents relating to the claim, and any appeal of an adverse benefit determination of the claim any request for external review/IRO of the claim if applicable.

I understand that in the absence of a contrary direction from me, UMR will direct all information and notices regarding the claim to which I otherwise an entitled, including benefit determinations, to my Authorized representative **only**.

I am aware that the Standards for Privacy of Individually Identifiable Health Information set forth by the U.S. Department of Health and Human Services (the "Privacy Standards") govern access to medical information. I understand that in connection with the performance of his/her duties hereunder, my Authorized Representative may receive my Protected Health Information, as defined in the Privacy Standards, relating to the claim. I hereby consent to any disclosure of my Protected Health Information to my Authorized representative.

Date: _____ _____
(Signature of patient or patient's guardian)

ACKNOWLEDGEMENT

I, _____ have read the above Designation of Authorized Representative and I hereby accept this designation and agree to act as Authorized Representative for (name) with respect to the above defined claim.

Date: _____ _____
(Signature of Authorized Representative)

Notices may be sent to the Authorized Representative at the following address:

Name _____

Street Address _____

City, State & Zip Code _____

Phone Number _____