NYCE Post Service Appeals
P.O. Box 211381
Eagan, MN 55121

EmblemHealth | UnitedHealthcare

Post-Service Appeals - Designation of Authorized Representative

I, _____, *(your name)* do hereby appoint,

_____ *(your Authorized Representative) (hereinafter "my Authorized Representative")* to act on my behalf in pursuing a benefit claim, specifically, my claim(s) for

_____ *(insert claim 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.

I understand that in the absence of a contrary direction from me, EmblemHealth/UnitedHealthcare will direct all information and notices regarding the claim to which I otherwise am 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 _____/_____/_____ Member ID _____
MM DD YYYY

Signature of patient or patient's guardian _____

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