Authorization of Representative

Section 1: Appointment of Representative

Member Name:__________________________ **Member ID Number:** _____________________

An Authorized Representative is a person you authorize to act on your behalf, in pursuing a claim or an appeal of a denied claim. This authorization may be either (1) granted for a particular event or date of service, after which time the authorization approval is revoked, or (2) granted for any present or future claim for health care benefits you may have. Designations of Authorized Representative status granted for a particular event or date of service are most appropriate when being granted to a health care provider or an attorney that may be representing you in connection with a claim. Designations of Authorized Representative status for any present or future claim for health care benefits are more appropriately made to family members or other trusted persons who you may wish to authorize to assist you in any present or future health care claim matters.

I, ____________________________, hereby appoint ____

(Name of person you are authorizing to act on your behalf)

as an Authorized Representative, to act on my behalf in the filing or pursuit of claims and/or appeals in connection with the following health care claims (check one):

__ ____; or

(Description of claim(s) issue, date(s) of service, provider(s) of service, and any other pertinent information)

__ any present or future claim for health care benefits.

Section 2: Acceptance of Appointment

To be completed by the representative:

I am a / an ____

(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative	Date	
Street Address	Phone Number	
City	State	Zip
Email Address (Optional)	Fax Number (Optional)	

Section 3: Authorized Representative Acknowledgement

I understand that, as a result of this authorization, Peak Health may disclose and release information concerning benefit eligibility, claim status, or claim approval or denial reasons in connection with the above referenced health care claims to the individual named above.

I understand that I may revoke this designation at any time by sending a written request to Peak Health at the contact information listed below or by calling Member Service: 1-833-5-MYPEAK (1-833-569-7325), Monday through Friday 8:00am to 5:00pm, excluding holidays. Such designation will be effective upon receipt by Peak, except to the extent that Peak Heath has taken action in reliance on this designation before receipt of the revocation. If not otherwise revoked, this designation will terminate 1 year from the date of this form is authorized.

______________________________	______________________________
Member Name (Print)	**Authorized Representative Name (Print)**
______________________________	______________________________
Member Signature and Date	**Authorized Representative Signature and Date**