Instructions for completing the Designation of Representative/Authorization Form



This form is to be used for a grievance or an appeal and to allow a party to act as the Authorized Representative in carrying out a grievance or an appeal.

If you have any questions, please feel free to call us at the customer service number on your member identification card. Please read the following for help completing page one of the form.

Part A: Member information

This section applies to the member who is asking for the release of his or her information to another person or company or a request to appoint an Authorized Representative. Please include as much information as you can.

- Print your last name, first name, and middle initial.
- Write your date of birth in this format: mmddyyyy. (If you were born on October 5, 1960, you would write 10051960.)
- Write your full street address, city, state, and ZIP code.
- Write your daytime phone number (including area code.)
- Write your cell/mobile number (including area code.)
- Identification number You will find this number on your member identification card.
- Group number

You will find this number on your member identification card. If your identification card does not have a group number leave this blank.

Part B: Person or company who can receive this information

- Check the box that applies to you. Write the full name of the person or company that you want us to give your information to. Please don't use a general term like "my daughter" or "my son" as it will not be accepted. You need to be specific.
- If you check "Other," give the first and last name (if available), the name of the company (if applicable), and how they relate to you.

Part C: Information that can be released

This section tells us what information you would like us to release: all or just some.

- For "all of your information," check the first box (this does not include sensitive information.)
- For "limited information," check the second box and the boxes that apply to you.
- Some topics may be very personal or sensitive to you. If you wish to approve the release of this type of information, check the box(es) that apply to you.

Designation of Repr				We	ellpoint		
This form is to be used for a party to act as the Authorized This form is to be filled out by person or company. Please in Representative not related to a Part A: Member information	Representative in a mindividual if a clude as much in a grievance and	in carrying out there is a requ information as	a grievance or an appeal. est to release an individua you can. (If an individual)	wants to de	formation to another signate an Authorized		
		Member first name		Middle initial	Member date of birth (MMDC 2 YY)		
Member street address		City	City		ZIP code		
Daytime phone number (with area code)	Cell/mobile ph (with area coo	one number	Identification number (see identification ca	Group number (see identification c			
Part B: Person or company	who will rece	ive this inforr	nation				
The following people or com Please enter first and last na							
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My domestic partner (enter	r first and last n	iame)	My insurance broker or company and first and	te broker or agent (enter the name of the d first and last name, if you have it)			
My adult children (enter fire	st and last nam	e[s])	Other (enter first and last name ,if you have it, name of company, and how it's regret to you)				
Part C: Information that ca	in be released						
I allow the following informa	tion to be used	or released by	Wellpoint on my behalf:				
information (see below	lers and financi	al information	(like billing and banking	condition),). This doe	claims, doctors and sn't include sensitive		
OR ☐ Only limited informati	on may be relea	ased (check al	I boxes below that apply	to you).			
☐ Appeal ☐ Benefits and cover ☐ Billing ☐ Claims and payme ☐ Doctor and hospit ☐ Diagnosis (name o	rage □Finar □Medi ent □Pre-o al (fort	cal records certification ar reatment appi	Id pre-authorization	Referral Treatment Dental Vision Pharmacy			
also approve the release of the All sensitive information		s of sensitive in	formation by Wellpoint (che	eck all boxes	that apply to you):		
☐ Just sensitive informa				andronatives !-	andah 3		
☐ Abuse (sexual/phy mental) ☐ Substance use dis ☐ Genetic testing		☐ HIV or AIDS ☐ Mental healt ☐ Sexually trar		oductive houding abor	ealth ³ tion, maternity, etc.)		
Specify time period of record Description of records that 2 Unless I specify otherwise of the specific of	may be disclosed	d:	cura to include all cubatana	o uso disor	dor records maintained		
2 Unless I specify otherwise of by Wellpoint about me. I un confidentiality laws and regu- in the laws and regulations. Part E. I understand that I c 3 Reproductive health include family planning, birth contr	derstand that my ulations and canr I also understand annot cancel this is, but it not limite	substance use not be disclosed that I may rev approval when ed to, both make	disorder records are proted without my written conservate (or cancel) this approvents form has already beer and female infertility, mate	cted under int unless of al at any tim n used to dis ernity, pregr	Federal and State herwise provided for ie, or as described in sclose information. nancy loss, miscarriage,		

Please read the following for help completing page two of the form.

Part D: Person or company who can act as my authorized representative

This section tells us who you have given the right to act as your Authorized Representative in carrying out a grievance or appeal. Part B and C must also be completed to authorize the release of your information.

- Check the box that applies to you. Write the full name of the person or company that you want to act as your Authorized Representative. Please don't use a general term like "my daughter" or "my son" as it will not be accepted. You need to be specific.
- If you check "Other", give the first and last name (if available), the name of the company (if applicable, and how they relate to you.

Part E: Date your approval expires

You have two choices of when you would like this approval to end.

- Check the first box for the conclusion of the grievance or appeal process.
- Check the second box for an earlier date (please provide details.)

Part F: Purpose of this approval

This section tells us the reason you've asked for the release of your information.

- Check the first box to let us know who to give out this information as shown on this form.
- Check the second box to let us know what information to give out (identified in Part C.)

Part G: Review and approval

- Sign your name and put the date on the form. Your name and signature must match the information in Part A.
- If you are signing this form on behalf of another person, or if you have Power of Attorney for healthcare, or are a legal guardian/conservator you must do the following:
 - You must complete the Designated Legal Representative/Guardian section.
 - You must also provide us with a copy of the legal document showing that you are approved and include it with this form.

is a person who you ap review rights that may above to authorize the	r company has the right to act a point to be your representative be available to you. They must t release of your information to you that applies and enter first and	in cárrying out a grievan be 18 years of age or old our Authorized Represer	ce or appeal, incluer. Please also co	orized Re uding any implete P	epresentative / external art B and C
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My domestic partner	(enter first and last name)	My insurance bro company and firs	ker or agent (ent t and last name,	er the na if you ha	me of the ve it)
My adult children (ent	er first and last name[s])	Other (enter first company, and how	and last name ,if w it's related to y	you have ou)	e it, name of
Part E: Date your app	roval expires				
If this document was ☐ At the conclusion of t ☐ One year from the sig	not already withdrawn, this ap the grievance or appeals process gnature date in Part G.	proval will end on the e . OR	arliest of the follo	owing da	tes:
Part F: Purpose of thi	s approval				
	to act as my Authorized Represe that may be available to me. on at my request.	entative in carrying out a	grievance or appea	al, includi	ng any
Part G: Review and a	pproval				
Wellpoint does not req being eligible for benef	uire that I sign this form in orde its.				ny rstand that rollment or
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Examples of legal documents:

- Health Care, General or Durable Power of Attorney. This document gives someone you trust the legal power to act on your behalf and make health care decisions for you.
- **Legal Guardianship.** This is when the court appoints someone to care for another person.
- Conservatorship. This happens when a judge appoints a responsible person to make decisions for someone who can't make responsible decisions for him/herself.
- Executor of estate. This type of document would be used when the person who is being represented has died.

Designation of Representative/Authorization Form



This form is to be used for a grievance or an appeal (see Section D) and to allow a party to act as the Authorized Representative in carrying out a grievance or an appeal. This form is to be filled out by an individual if there is a request to release an individual's health information to another person or company. Please include as much information as you can. (If an individual wants to designate an Authorized Representative not related to a grievance and appeal, use the Member Authorization form.)

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Member last name		Member first name		Middle initial	Member date of birth (MMDDYYYY)		
Member street address		City		State	ZIP code		
Daytime phone number (with area code)	Cell/mobile ph (with area cod	one number e)	Identification number (see identification care	Group (see id	up number dentification card)		
Part B: Person or company	who will recei	ve this inforn	nation	. !			
The following people or comp Please enter first and last nar	right to receive first/last name	re my information. They must be 18 years of age or older. e below, that person may receive my information.					
My spouse (enter first and last name)			My parents (if you are o	over 18 — ent	er first and last name[s])		
My domestic partner (enter first and last name)			My insurance broker or agent (enter the name of the company and first and last name, if you have it)				
My adult children (enter firs	t and last name	e[s])	Other (enter first and company, and how it's	last name ,if s related to yo	you have it, name of ou)		
Part C: Information that car	be released						
Check only one box. All my information. Thi other healthcare provide information (see below) OR Only limited information Appeal Benefits and covera Billing Claims and payment Doctor and hospital	ers and financia unless it is app on may be relea Eligib age Financia Medic nt Pre-co I (for tr	Il information proved below. sed (check all ility and enrol cial cal records ertification an reatment appredition) and production) and production and production and production.	(like billing and bankin boxes below that apply lment displayed by the light of the	g). This does y to you). ☐ Referral ☐ Treatment ☐ Dental ☐ Vision ☐ Pharmacy	en't include sensitive		
I also approve the release of the □ All sensitive information	0 7 1	of sensitive inf	ormation by Wellpoint (cl	neck all boxes	that apply to you):		
OR) II -						
☐ Just sensitive informat	•				141. 2		
□ Abuse (sexual/physmental)□ Substance use disc□ Genetic testing		HIV or AIDS Mental health Sexually tran	□ Rep n (ind smitted illness	productive he cluding abort	ealth ³ ion, maternity, etc.)		
1 Specify time period of record Description of records that n	ls to be disclose hav be disclosed	d:					
2 Unless I specify otherwise of by Wellpoint about me. I und confidentiality laws and regulations. I Part E. I understand that I ca 3 Reproductive health includes family planning, birth control	n this form, I inte erstand that my lations and cann also understand nnot cancel this	end this disclos substance use ot be disclosed I that I may reve approval when	cure to include all substar disorder records are pro- l without my written cons oke (or cancel) this appro- this form has already bee and female infertility, ma s abortion, and any other	nce use disorce tected under Feent unless other of the control of	ler records maintained lederal and State nerwise provided for e, or as described in close information. ancy loss, miscarriage, r services		

Part D: Person or company who can act as my authorized representative The following person or company has the right to act as my Authorized Representative. An Authorized Representative is a person who you appoint to be your representative in carrying out a grievance or appeal, including any external review rights that may be available to you. They must be 18 years of age or older. Please also complete Part B and C above to authorize the release of your information to your Authorized Representative. Please check each box that applies and enter first and last name. My spouse (enter first and last name) My parents (if you are over 18 — enter first and last name[s]) My insurance broker or agent (enter the name of the My domestic partner (enter first and last name) company and first and last name, if you have it) My adult children (enter first and last name[s]) Other (enter first and last name, if you have it, name of company, and how it's related to you) Part E: Date your approval expires If this document was not already withdrawn, this approval will end on the earliest of the following dates: ☐ At the conclusion of the grievance or appeals process. **OR** ☐ One year from the signature date in Part G. Part F: Purpose of this approval ☐ To allow an individual to act as my Authorized Representative in carrying out a grievance or appeal, including any external review rights that may be available to me. ☐ To disclose information at my request. Part G: Review and approval I have read the contents of this form. I understand, agree, and allow Wellpoint to the use and release of my information as I have stated above. I also understand that signing this form is of my own free will. I understand that Wellpoint does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits. I have the right to withdraw this approval at any time by giving written notice of my withdrawal to Wellpoint. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form. Member signature or Designated Legal Representative/Guardian signature Date (MMDDYYYY) Designated Legal Representative/Guardian -Complete this section only if you have documentation supporting Legal Representation. If this form is signed by someone other than the member or parent, such as a personal representative, legal representative or guardian on behalf of the member, please submit the following:

- A copy of a healthcare, general or Durable Power of Attorney.
- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.

Please complete the following:

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Legal representative (print full name)		Legal relationship	to me	ember
Legal representative street address	City		State	ZIP code
Signature V		D	ate (N	(MDDYYYY)

Please return the completed form to:

Wellpoint

Services provided by Wellpoint Life and Health Insurance Company. For Medicaid, services provided by: In Iowa: Wellpoint Iowa, Inc.; In Maryland: Wellpoint Maryland, Inc.; In New Jersey: Wellpoint New Jersey, Inc.; In Tennessee: Wellpoint Tennessee, Inc.; In Texas: members in the Medicaid Rural Service Area and the STAR Kids programs are served by Wellpoint Insurance Company; all other Wellpoint members in Texas are served by Wellpoint Texas, Inc.; In Washington: Wellpoint Washington: Wellpoint Washington; Inc. In West Virginia: Wellpoint West Virginia, Inc. For Medicare Part C, services provided by: In Arizona: Wellpoint Texas, Inc. or Wellpoint Ohio, Inc. for HMO products, and Wellpoint Insurance Company for LPPO products; In Iowa: Wellpoint Iowa, Inc.; In New Jersey: Wellpoint New Jersey: Inc. or Wellpoint Texas, Inc. for HMO products, and Wellpoint Insurance Company for LPPO products; In Texas: Wellpoint Texas, Inc. or Wellpoint Insurance Company. For Medicare Part D (Arizona & Texas), services provided by Wellpoint Insurance Company.