Humana

Grievance and Appeal Department

APPOINTMENT OF AUTHORIZED REPRESENTATIVE FORM

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

I, _____ , appoint Stephanie Stuart

Name of Member — 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 , hereby accept the above appointment.

Name of Authorized Representative

I am a/an A/R Analyst

Relationship to member

Stephanie Stuart

Signature of Authorized Representative **Date** _____

Address: Western Ohio Sedation Associates, LLC Telephone Number: 888-337-3509

PO Box 865666

Orlando FL 32886

* 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.