Authorization of Designated Appeals Representative

Capital

Section I—Member Information

I authorize _____ to act as my representative in connection
(NAME OF THE INDIVIDUAL APPOINTED AS REPRESENTATIVE)
with my complaint, grievance, or appeal with Capital Blue Cross, or Keystone Health Plan® Central, Inc. I have read this consent, including the instructions on the back of this form, or have had it read to me and it has been explained to my satisfaction. I understand this information and grant my consent for my representative to file a complaint, grievance, or appeal on my behalf.

First name:	Last name:	Date of birth (MM/DD/YY):
ID prefix (see ID card):	ID number:	Group/policy number:
Address:		
City/state:	ZIP Code:	Phone number:
Member signature:	Relationship to member:	Date:
Signature of witness:		Date:

If you are completing on behalf of a minor – enter the child's name and date of birth for the member information. The subscriber must have a handwritten, ink signature and date the form to be valid.

If your appeal is related to behavioral health – per Pennsylvania Act 147 (please see back of form), any member age 14+ years of age MUST have a handwritten, ink signature from the subscriber, parent, or representative permission to appeal on their behalf.

Signature of witness – HMO, POS, Gatekeeper PPO products only. (See ID card.)

Section II—Acceptance of Authorization

To be completed by the Representative:

I, _____ hereby accept the above referenced appointment.
(NAME OF THE INDIVIDUAL APPOINTED)

I am a/an _____
(RELATIONSHIP TO THE PARTY, E.G., ATTORNEY, RELATIVE, ETC.)

of the member and will advocate on their behalf in regards to the complaint, grievance, or appeal.

Representative name:	Relationship to member:	
Address:		
City:	State:	ZIP Code:
Daytime phone:	Evening phone:	
Signature of representative:	Date:	

This form and any accompanying documents may be mailed or faxed as follows to:
Member Appeals Department, Capital Blue Cross, PO Box 779518, Harrisburg, PA 17177-9518; Fax: 717.541.6915

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IMPORTANT: To avoid any delay in the processing of your complaint, grievance, or appeal, please verify that all information needed has been completed. If any of the required elements listed on page 1 are missing, a handwritten ink signature is not present, or any information determined to be invalid, the authorization form will be returned for corrections.

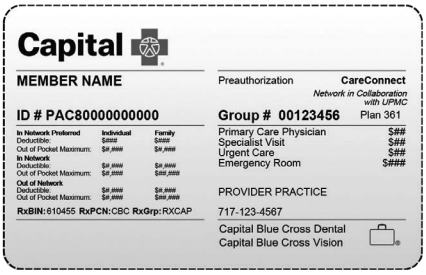
Section I – Authorization of Designated Appeals Representative (ADAR) – The name of the party making the appointment must be clearly legible, including the address and phone number. The form must also include a handwritten ink signature and date in order to be valid. If the party that wishes to appoint a representative is a member, only the member or member's legal guardian may sign. If the party making the appointment is the provider or supplier, the provider or supplier (or person authorized to act on behalf of the provider or supplier) must complete this section with a handwritten ink signature and date.

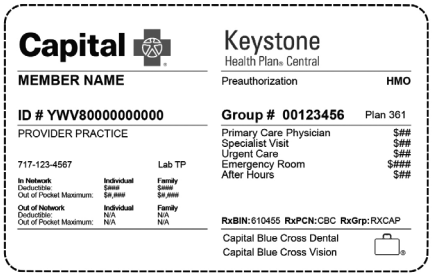
By signing Section I, you agree that the representative listed will act on your behalf regarding the complaint, grievance, or appeal submitted. I understand that:

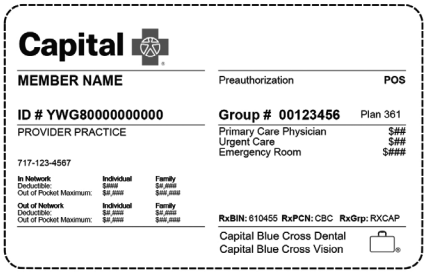
1. I will not be able to file my own complaint, grievance, or appeal concerning the same services, nor will any other representative I appoint, unless this consent is rescinded in writing.
2. I have the right to rescind this consent at any time. My legal representative also has the right to rescind this consent at any time.
3. When the plan takes action or issues correspondence, it shall send notice to only the authorized representative. Notice shall not be sent to the party if there is an authorized representative.
4. The plan shall send any request for information or evidence regarding an appeal only to the authorized representative.

Pennsylvania Act 147 – Capital Blue Cross follows Pennsylvania Act 147, which requires individuals 14 years of age and older to sign an authorization form in order to release behavioral health-related information to third parties. For more information, please visit **dhs.pa.gov**.

Witness signature pertaining to Act 68 – Complete this field if your card reads; CareConnect, HMO, or POS.







Section II – Acceptance of authorization – An organization or entity may not be named as a representative, but rather a specific member of that organization or entity must be named. This ensures that the confidential member information is released only to the individual so names. The name of the individual appointed as representative must always be completed, and his/her relationship to the party entered. The individual being appointed must also complete Section II, including a handwritten ink signature and date to be valid. The representative must sign the authorization within 30 calendar days of the party listed in Section I.

By signing Section II, as the authorized representative, I am accountable to:

1. Inform the party of the scope and responsibilities of the representation;
2. Inform the party of the status of the complaint, grievance, or appeal and the results of actions taken on behalf of the party such as notification of complaint, grievance, or appeal determinations, decisions, and further appeal rights; and
3. Disclose to the member any financial risk and liability that the member may have.

Authority of an ADAR: A representative may represent a party in a complaint, grievance, or appeal. An authorized representative may, on behalf of the party, obtain complaint, grievance, or appeal information to the same extent as the party; submit evidence; make statements about facts and law; and make any request; or give or receive any notice about the complaint, grievance, or appeal records.

Duration of authorization:

1. An authorization is considered valid for one (1) year from the date that both parties signed the form. Requiring that a new authorization be executed on a yearly basis will help ensure that there is an ongoing relationship between the party and his/her representative.
2. Appeals for other claims may be initiated utilizing an existing authorization instrument within one year of the effective date of the authorization (i.e., the date a completed authorization instrument is signed by the party and the appointed representative). When initiating a new appeal within the one year time frame, the representative must file a copy of the completed ADAR Form with the complaint, grievance, or appeal request. Allowing the representative to use the same authorization for up to one year will help reduce the paperwork involved in representing parties.
3. The authorization remains valid throughout any and all subsequent levels of complaint, grievance, or appeal on the item(s), claim(s) or service(s) at issue. Therefore, the representative need not secure a new authorization when proceeding to the next level of complaint, grievance, or appeal on the same items, services or claim(s). This holds true regardless of the length of time it may take to resolve the complaint, grievance, or appeal.