



Federal Employee Program.

**FEDERAL EMPLOYEE PROGRAM
DESIGNATION OF REPRESENTATIVE AS AUTHORIZED
REPRESENTATIVE FOR THE DISPUTED CLAIMS PROCESS**

Name of the Blue Cross and Blue Shield Service Benefit Plan member:

Name of person granting authorization and relationship to Service Benefit Plan member (*if other than the member*) (e.g., parent, personal representative):

I designate the following representative _____ (*insert name of doctor, hospital division, laboratory, health plan or other entity*) as my authorized representative to appeal the claims decision listed below:

This authorization is for the sole purpose of allowing me, as the member, or my named personal representative to dispute the items noted below, and expires upon completion of the disputed claims process:

Pre-Service Reference # _____

Claim # _____

Refund Request Document # _____

Other _____



Federal Employee Program.

As necessary for this appeal, I authorize the use and disclosure of my protected health information¹ as follows:

I authorize the Blue Cross and Blue Shield Federal Employee Program (FEP) to release protected health information including all medical records, medical rationale, or relevant reference materials FEP used in making their benefit denial decision to my authorized representative. The authorized individual(s) or organization(s) I select to receive this information are:

(Insert the name of the person(s) or organization(s) authorized to receive your protected health information.)

I do not wish to have the following protected health information disclosed:

*(Describe in as much detail as possible the protected health information that you **do not** wish to be used or disclosed. For example, the information to be used or disclosed may relate to payment, enrollment, or claims. You should include, if available, the types of claims, dates of service, or types of service.)*

I understand that I may withdraw this authorization at any time by sending a written notification to my Local Blue Cross and Blue Shield Plan² and this withdrawal will be effective for future uses and disclosures of protected health information. However, I further understand that this withdrawal will not be effective for information that the Service Benefit Plan already has used or disclosed, relying on this authorization.

Signature of Member or Personal Representative

Date

Name of Provider Pursuing Internal Appeal

If a covered entity is requesting this Authorization, the covered entity must provide the member a signed copy of this document.

¹Protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a healthcare provider, a health plan, my employer, or a healthcare clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of healthcare to me.

² Address can be located under the Plan Contact Information at www.fepblue.org/contact