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.)
- **10** 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 Repre	sentative/Auth	orization Fo	orm		HealthLin			
This form is to be used for a gr out a grievance or an appeal. T to another person or company Representative not related to Part A: Member information	his form is to be fille Please include as m a grievance and appe	d out by an indivi uch information a	dual if there is a request to as you can. (If an individual	release an indi	vidual's health informatio			
Member last name		Member first n	ame	Middle initial	Member date of birth (MMDDYYYY)			
Member street address			City		ZIP code 2			
Daytime phone number (with area code)	Cell/mobile phor (with area code)	ne number	Identification number (see identification card)	Group number (see identification card)				
Part B: Person or company The following people or com Please enter first and last no	anies have the righ	t to receive my i						
My spouse (enter first and las		regional fields	My parents (if you are ov					
My domestic partner (enter first and last name)			My insurance broker or and first and last name, if	My insurance broker or agent (enter the name of the 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)					
I allow the following informa Check only one box. All my information. This providers and financial it is approved below. OR	can include health,	a diagnosis (nar	,	claims, doctors tive information	s and other healthcare on (see below) unless			
Only limited information Appeal Benefits and cove Billing Claims and payme Doctor and hospit Diagnosis (name of	rage nt al f illness or condition	□ Eligibility and □ Financial □ Medical recor □ Pre-certificati (for treatmen n) and procedure	enrollment ds on and pre-authorization t approvals) (treatment):	Referral Treatment Dental Vision Pharmacy				
l also approve the release of All sensitive informations OR		of sensitive info	rmation by HealthLink (che	ck all boxes th	at apply to you):			
☐ Just sensitive informat ☐ Abuse (sexual/phy ☐ Substance use dis ☐ Genetic testing 1 Specify time period of record	sical/mental) order ^{1,2}	ecked below HIV or AIDS Mental health Sexually trans		Reproduct (including	ive health³ abortion, maternity, etc.			
Description of records that n 2 Unless I specify otherwise or about me. I understand that and cannot de disclosed with revoke (or cancel) this appro already been used to disclos	nay be disclosed: I this form, I intend the my substance use dis out my written conse val at any time, or as e information.	order records are nt unless otherwis described in Part	clude all substance use diso protected under Federal and se provided for in the laws ar E. I understand that I cannot male infertility, maternity, pi	State confiden id regulations. I cancel this app	tiality laws and regulations also understand that I may roval when this form has			

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.

- Oheck 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.

The following person or company has the right to act as my At who you appoint to be your representative in carrying out a gr available to you. They must be 18 years of age or older. Please information to your Atthorized Representative. Please check each box that applies and enter first and last nar	rievance or appeal, includin e also complete Part B and	an Authorized Repre ng any external revi l C above to authoriz	ew rigi ze the	tive i hts th relea	s a person at may be se of your	
My spouse (enter first and last name) My parents (if you are over 18 – enter first and last name)s						
My domestic partner (enter first and last name)	My insurance broker and first and last name	roker or agent (enter the name of the company t 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 At the conclusion of the grievance or appeals process. OF One year from the signature date in Part G.		following dates:				
Part F: Purpose of this approval						
 □ To allow an individual to act as my Authorized Representati rights that may be available to me. □ To disclose information at my request. 	ve in carrying out a grieva	nce or appeal, inclu	ding a	ny ex	ternal revi	ew
Part G: Review and approval						
I have read the contents of this form. I understand, agree, and stated above. I also understand that signing this form is of my this form in order for me to receive treatment or payment, or I have the circle to read the significant to the state of the significant to the signific	own free will. I understand for enrollment or being elig	d that HealthLink dó gible for benefits.	oes no	t requ	iire that I s	ign
stated above. I also understand that signing this form is of my this form in order for me to receive treatment or payment, or! I have the right to withdraw this approval at any time by giving withdrawing this approval will not affect any action taken befing given out by the person or group who receives it. If this happe entitled to a copy of this form.	own free will. I understan for enrollment or being elig gwritten notice of my with ore I do so. I also understa ns, it may no longer be pro	d that HealthLink dó gible for benefits. drawal to HealthLinl nd that information	k. I und that's IPAA P	t requ dersta relea rivac	ire that I s and that my ased may b y Rule. I am	ign y ie
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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.)

Part A: Member information								
Member last name		Member first nar	me	Middle initial	Member date of birth (MMDDYYYY)			
Member street address		City		State	ZIP code			
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Daytime phone number Cell/mobile phone number Identification number Group number (with area code) (with area code) (see identification card) (see identification card) Part B: Person or company who will receive this information The following people or companies have the right to receive my information. They must be 18 years of age or older. Please enter first and last name. By entering first/last name below, that person may receive my information. 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 company My domestic partner (enter first and last name) and first and last name, if you have it) **Other** (enter first and last name, if you have it, name of company, My adult children (enter first and last name[s]) and how it's related to you) Part C: Information that can be released I allow the following information to be used or released by HealthLink on my behalf: Check only one box. ☐ **All my information**. This can include health, a diagnosis (name of illness or condition), claims, doctors and other healthcare providers and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below. OR □ **Only limited information** may be released (check all boxes below that apply to you). ☐ Eligibility and enrollment □ Appeal □ Referral □ Benefits and coverage ☐ Financial \square Treatment □ Billing ☐ Medical records \square Dental \square Claims and payment ☐ Pre-certification and pre-authorization \square Vision (for treatment approvals) ☐ Doctor and hospital □ Pharmacy ☐ Diagnosis (name of illness or condition) and procedure (treatment): I also approve the release of the following types of sensitive information by HealthLink (check all boxes that apply to you): ☐ All sensitive information ² OR ☐ Just sensitive information about topics checked below ☐ Abuse (sexual/physical/mental) ☐ HIV or AIDS ☐ Reproductive health ³ ☐ Substance use disorder 1,2 ☐ Mental health (including abortion, maternity, etc.) ☐ Sexually transmitted illness ☐ Genetic testing 1 Specify time period of records to be disclosed: Description of records that may be disclosed: 2 Unless I specify otherwise on this form, I intend this disclosure to include all substance use disorder records maintained by HealthLink about me. I understand that my substance use disorder records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time, or as described in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

HealthLink®, Inc., is an Illinois corporation. HealthLink, Inc. is an organizer of independently contracted provider networks, which it makes available by contract to a variety of payors of health benefits, including insurers, third party administrators or employers. HealthLink has no control over the professional, medical judgment of contracted providers, and is not liable for any acts or failures to act, by contracted providers. HealthLink, Inc. is not an insurance company and has no liability for benefits under benefit plans offered or administered by payors. HealthLink® is a registered trademark of HealthLink, Inc.

birth control, both elective and spontaneous abortion, and any other related care or services.

3 Reproductive health includes, but it not limited to, both male and female infertility, maternity, pregnancy loss, miscarriage, family planning,

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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 company and first and last name, if you have it) My domestic partner (enter first and last name) Other (enter first and last name, if you have it, name of company, My adult children (enter first and last name[s]) 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: \square At the conclusion of the grievance or appeals process. \square 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. \square To disclose information at my request. Part G: Review and approval I have read the contents of this form. I understand, agree, and allow HealthLink 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 HealthLink 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 HealthLink. 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: Legal representative (print full name) Legal relationship to member Legal representative street address City State | ZIP code

Please return the completed form to:

By mail: Grievances and Appeals P.O. Box 411424 St. Louis, MO 63141

Signature

By fax: 1-314-925-6637

Date (MMDDYYYY)