INSURANCE MANAGEMENT SERVICES
P.O. Box 15688 • Amarillo, TX 79105

DESIGNATION OF AUTHORIZED REPRESENTATIVE

I, _____, do hereby appoint _____
(PLEASE PRINT) (PLEASE PRINT)
(hereinafter "my Authorized Representative") to act on my behalf in pursuing a benefit claim, specifically, _____
(Description of Claim for Health Benefits, for example, date of service)
(the "Claim") My Authorized Representative shall have full authority to act, and receive notices, on my behalf with respect to an initial determination of the Claim, any requests for documents relating to the Claim, and any appeal of adverse determination of the Claim.

I understand that in the absence of a contrary direction from me, _____ (the "Plan") will direct all
(Name of the Health Plan)
Information and notices regarding the Claim to which I otherwise am entitled, including benefit determinations, to my Authorized Representative **only**.

I am aware that the Standards for Privacy of Individually Identifiable Health Information set forth by the U.S. Department of Health and Human Services (the "Privacy Standards"), govern access to medical information. I understand that in connection with the performance of his/her duties hereunder, my Authorized Representative may receive my Protected Health Information, as defined in the Privacy Standards, relating to the Claim. I hereby consent to any disclosure of my Protected Health Information to my Authorized Representative.

Date:_____ _____
(SIGNATURE OF CLAIMANT)

ACKNOWLEDGMENT

I, _____, have read the above Designation of Authorized
(Name of Authorized Representative)
Representative and I hereby accept this designation and agree to act as Authorized Representative for _____ with respect to the Claim defined
(Name of Claimant)
above.

Date:_____ _____
(SIGNATURE OF REPRESENTATIVE)