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

DESIGNATION OF AUTHORIZED REPRESENTATIVE

I, _____, do hereby appoint _____
(Patient/Member Full Name – PLEASE PRINT) (Provider and/or Representative Full Name – PLEASE PRINT)
hereinafter referred to as "my Authorized Representative", to act on my behalf in pursuing a benefit claim.

Description of Claim: (Include date(s) of service, provider name, or treatment details)

_____

_____

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, _____
(Name of Group Health Plan)
will direct all 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.

Signature of Claimant (Patient/Member): _____ Date: _____

ACKNOWLEDGMENT BY AUTHORIZED REPRESENTATIVE

I, _____, have read and understand the above
(Authorized Representative's Full Name – PLEASE PRINT),
Designation of Authorized Representative. I accept the designation and agree to act on behalf of,

_____, with respect to the claim described above.
(Claimant's Full Name – PLEASE PRINT)

Signature of Authorized Representative: _____ Date: _____