KAISER PERMANENTE®

APPOINTMENT OF REPRESENTATIVE – Page 1 of 3

If you wish to give authority to another party to file: (1) a complaint/grievance, (2) a claim, and/or (3) an appeal on your behalf, please complete the following information. If you wish this person to make inquiries regarding your treatment and care and receive your Protected Health Information (PHI), you must check the appropriate box(es) below and you and your representative must both sign and date this form. **Please return the completed form with the request you are submitting.**

PART A (For Member/Patient): I understand that Kaiser Permanente[1] will not condition treatment, payment, enrollment, or eligibility for benefits on my providing or refusing to provide this authorization.

Member/Patient Printed Name:	Address:
Daytime Phone:	Alternate Phone:
Medical Record #:	Medicare Member: Y / N Medicare # (if applicable):

Please select one of the following:

□ I authorize Kaiser Permanente to disclose PHI regarding my medical condition and care and/or payment information to the individual designated in Part B. This information must be relevant to the request filed with Customer Relations or Member Service Center on (insert date of request) _____. This authorization will remain in effect for the life of the request for which it is being submitted or until written revocation (whichever occurs first).

□ I authorize Kaiser Permanente to disclose PHI regarding my medical condition and care and/or payment information to the individual designated in Part B. This information must be relevant to any request filed (as checked below) with Customer Relations or Member Service Center for the balance of the calendar year in which this authorization was submitted. This authorization will remain in effect for the balance of the calendar year in which the request was submitted or until written revocation (whichever occurs first).

□ **Complaint/Grievance** □**Appeal** □ **Appointment Scheduling** □ **Claims**

PHI release to Appointed Representative OK to include the following Information: Please check all that apply. □ Medical □ Psychiatric □ Drug/Alcohol □ Results of an HIV blood test

I hereby authorize the individual designated in Part B to represent me regarding concerns with the quality of care or service I have received from Kaiser Permanente, or in questions regarding coverage of services or supplies I may be entitled to as a member of Kaiser Permanente. I understand that this authorization is voluntary and, if I choose to do so, I have the right to revoke it in writing to Kaiser Permanente and to my designated representative. Kaiser Permanente and my appointed representative may not use or disclose my PHI relevant to this authorization except to the extent Kaiser Permanente or my appointed representative has taken action in reliance upon this authorization.

X Member/Patient SIGNATURE: _____ DATE: _____

[1] Collectively herein "Kaiser Permanente" refers to: Kaiser Foundation Health Plan of Ohio, The Ohio Permanente Medical Group, Inc., and Kaiser Permanente Insurance Company.

PART B (For Appointed Representative):

Printed Name of Appointed Person:	Relationship:
Address:	City, State & Zip:
Daytime Phone:	Alternate Phone:

REDISCLOSURE: I understand that as the recipient of the above member/patient's PHI, I may not lawfully further use or disclose the PHI other than the intended purpose as stated herein unless another authorization is obtained from this member/patient or unless such use or disclosure is specifically required or permitted by law.

I hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the representative; and that I recognize that any fee in relation to my appointment may be subject to review and approval by the Secretary of the Department of Health and Human Services.
X Appointed Representative SIGNATURE: _____ DATE: _____

WAIVER OF FEE FOR REPRESENTATION: If the member/patient being represented is a Medicare beneficiary, the Appointed Representative must read and sign below.

I waive my right to charge and collect a fee for representing (insert the name of the member/patient being represented) _____ before the Secretary of the Department of Health and Human Services.
X Appointed Representative SIGNATURE: _____ DATE: _____

PART C (Only for members/patients with an authorized representative):

I am authorized to sign this authorization on behalf of the above member/patient on the basis of:
□ Legal Authority (Power of Attorney, etc.) □ Written Designation by Member
□ Parent, Guardian, or other individual acting in loco parentis.

If this authorization is for a deceased member/patient, please provide the appropriate legal documentation of appointment.
X SIGNATURE of Authorized Representative (if applicable): _____ DATE: _____

REVOCATION: This Authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this Authorization.

Member/Patient has a right to a copy of this form.
For release of medical records, please contact Medical Correspondence, Monday-Friday, 8:30 a.m. to 5 p.m., at 216-749-8448 or 1-866-749-8448. Hearing or speech impaired members may contact Customer Relations at (TTY/TDD) (216) 635-4444 or 1-877-676-6677, Monday –Thursday, 8:15 a.m. to 5 p.m. and Friday, 9 a.m. to 5 p.m.

PART D: Waiver of Payment for Items or Services at Issue.
Instructions: Providers or suppliers that furnished the items or services at issue must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, and could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

Provider/Supplier SIGNATURE: _____ DATE: _____
I waive my right to collect payment from the beneficiary for furnished items or services at issue involving 1879(a)(2) of the Act.

CHARGING OF FEES FOR REPRESENTING BENEFICIARIES BEFORE THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Department of Health and Human Services (DHHS) at the Administrative Law Judge (ALJ) or Medicare Appeals Council (MAC) level is required by law to obtain approval of the fee in accordance with 42 CFR §405.910(f). A claim that has been remanded by a court to the Secretary for further administrative proceedings is considered to be before the Secretary after the remand by the court.

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with DHHS. Where a representative has rendered services in a claim before DHHS, the regulations require that the amount of the fee to be charged, if any, for services performed before the Secretary of DHHS be specified. If any fee is to be charged for such services, a petition for approval of that amount must be submitted.

An approval of a fee is not required where the appellant is a provider or supplier or where the fee is for services (1) rendered in an official capacity such as that of legal guardian, committee, or similar court-appointed office and the court has approved the fee in question; (2) in representing the beneficiary before the federal district court of above, or (3) in representing the beneficiary in appeals below the ALJ level. If the representative wishes to waive a fee, he or she may do so. Part B on page 2 of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation.

AUTHORIZATION OF FEE

The requirement for the approval of fees ensures that representative will receive fair value for the services performed before DHHS on behalf of a claimant while at the same time giving a measure of security to the beneficiaries. In approving a requested fee, the ALJ or MAC considers the nature and type of services performed, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

CONFLICT OF INTEREST

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.