Clear Form

APPOINTMENT OF REPRESENTATIVE

Please complete this form in its entirety and submit the completed form along with your appeal or grievance and any supporting documentation to:

Delta Dental
P.O. Box 30416
Lansing, MI 48909-7916

Member Name

Member ID Number

Street Address

Phone Number

City

State

Zip Code

Appointed Representative

Relationship to Member

Description of PHI to be released:

_____

_____

Please list any limitations that you may want restricted to the PHI that is released to the person(s) and/ or organization(s):

_____

_____

Please list the purpose for this PHI release authorization:

_____

_____

This authorization is to expire on .

Delta Dental may not deny you treatment, payment, enrollment or eligibility for benefits if you refuse to sign this authorization.

If the person or entity receiving your PHI is not a health care provider, health plan or health insurance issuer subject to federal privacy regulations, the information described above may be disclosed by that person or entity to other individuals or entities and therefore no longer protected by HIPAA and/or other federal privacy regulations.

Appointment of Representative:

To be completed by the member

I,_____, do hereby name_____, to act as my authorized representative in connection with my claim. I authorize this individual to make any request; to present or to elicit evidence; to obtain grievance or appeal information; and to receive any notice in connection with my grievance or appeal. I understand that personal medical information related to my grievance or appeal may be disclosed to my authorized representative.

_____. _____.

Signature Date

I understand that I may revoke this authorization at any time, by submitting a request in writing to the address listed above.

For internal use only: Forward to Focused Review