DESIGNATION OF AN AUTHORIZED REPRESENTATIVE (DOR)
(Failure to complete this form in its entirety will invalidate this authorization)

An Authorized Representative is a person you authorize to act on your behalf, in pursuing a claim or an appeal of a denied claim. This authorization may be either (1) granted for a particular event or date of service, after which time the authorization approval is revoked, or (2) granted for any present or future claim for health care benefits you may have. Designations of Authorized Representative status granted for a particular event or date of service are most appropriate when being granted to a health care provider or an attorney that may be representing you in connection with a claim. Designations of Authorized Representative status for any present or future claim for health care benefits are more appropriately made to family members or other trusted persons who you may wish to authorize to assist you in the future with health care claim matters.

I, _____ , hereby appoint _____
(name of person you are authorizing to act on your behalf)

As an Authorized Representative, to act on my behalf in the filing or pursuance of claims and pursuance of appeals in connection with the following health care claim(s):

☐ _____

_____

(Include specific claim(s) issue, date(s) of service, provider(s) of service, and any other pertinent information available)

OR

☐ **Any present or future claim for health care benefit**s.

I understand that as a result of this authorization, *AmeriBen* may disclose and release information concerning benefit eligibility, claim status, or claim approval or denial reasons in connection with the above referenced health care claims to the individual named above. This designation is subject to revocation at any time by the designator except to the extent that *AmeriBen* has taken action in reliance on this designation before it knew of the revocation. If not previously revoked, this designation will terminate on:

_____ (Specify date, time, event and/or condition)

I certify that I have read and understand this Authorization, and that the information in it is true and correct.

_____ _____
Print name of patient | Print name of personal representative, if applicable

_____ _____
Signature of patient and date | Signature of personal representative and date

SIGNING THIS AUTHORIZATION IS NOT A PREREQUISITE TO YOUR PARTICIPATION IN THE PLAN