

Authorized Representative Appointment and Authorization for Release of Information

Member Name: _____
I.D. Number: _____
Address: _____
City, State, ZIP: _____
Telephone Number: _____

I appoint the individual named below as the Authorized Representative to act on my behalf with Avera Health Plans for the purpose of (check all that apply):

- My inquiries and claims for health care benefits with the dates of service (specify):

- All inquiries and claims for health care benefits limited to the following dependent members (specify names):

- All my claims or inquiries for health care benefits on and after the effective date of this Appointment.

- My appeal of denied claim(s) with the date(s) of service (specify):

- Other (specify):

This Appointment is effective upon Avera Health Plans' receipt of a fully completed and signed original or exact copy of this form at the address stated below. This Appointment may be revoked at any time upon written notice to Avera Health Plans, unless Avera Health Plans has taken action in reliance upon the Appointment or the Appointment was obtained as a condition of enrollment. In the event this Authorization is revoked, Avera Health Plans may use, disclose or obtain Protected Health Information under other provisions of law and as described in Avera Health Plans' Notice of Privacy Practices. This Appointment will expire upon (check one):

- Termination of Enrollment
- Date (specify): _____
- Event (specify): _____

I authorize the release and disclosure of any and all personal health information, including claims, mental health, substance abuse (drug or alcohol), and AIDS-related information, if applicable, to the individual named below as long as this Appointment is in effect.

Avera Health Plans will not condition treatment, payment, enrollment or eligibility for benefits based on the signing of this Appointment, unless this is for Avera Health Plans' underwriting or risk-rating determinations.

