BlueCross BlueShield
Federal Employee Program

FEDERAL EMPLOYEE PROGRAM
DESIGNATION OF REPRESENTATIVE AS AUTHORIZED REPRESENTATIVE FOR THE DISPUTED CLAIMS PROCESS

Name of the Blue Cross and Blue Shield Service Benefit Plan member:

_____

Name of person granting authorization and relationship to Service Benefit Plan member (*if other than the member*) (*e.g.*, parent, personal representative):

_____

I designate the following representative_____ (*insert name of doctor, hospital division, laboratory, health plan or other entity)* as my authorized representative to appeal the claims decision listed below:

This authorization is for the sole purpose of allowing me, as the member, or my named personal representative to dispute the items noted below, and expires upon completion of the disputed claims process:

Pre-Service Reference #_____

Claim #_____

Refund Request Document #_____

Other_____

_____

_____

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As necessary for this appeal, I authorize the use and disclosure of my protected health information[1] as follows:

I authorize the Blue Cross and Blue Shield Federal Employee Program (FEP) to release protected health information including all medical records, medical rationale, or relevant reference materials FEP used in making their benefit denial decision to my authorized representative. The authorized individual(s) or organization(s) I select to receive this information are:

_____

(Insert the name of the person(s) or organization(s) authorized to receive your protected health information.)

I do not wish to have the following protected health information disclosed:

_____

_____

*(Describe in as much detail as possible the protected health information that you **do not** wish to be used or disclosed. For example, the information to be used or disclosed may relate to payment, enrollment, or claims. You should include, if available, the types of claims, dates of service, or types of service.)*

I understand that I may revoke this authorization at any time by sending a written notification to the local Blue Cross and Blue Shield Plan and this revocation will be effective for future uses and disclosures of protected health information. (Address can be located under the Plan Contact Information at www.fepblue.org/contact). However, I further understand that this withdrawal will not be effective for information that the Service Benefit Plan already has used or disclosed, relying on this authorization.

_____ _____

Signature of Member or Personal Representative Date

_____

Name of Provider Pursuing Internal Appeal

If a covered entity is requesting this Authorization, the covered entity must provide the member a signed copy of this document.

[1]Protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a healthcare provider, a health plan, my employer, or a healthcare clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of healthcare to me.