DESIGNATION OF PROVIDER AS AUTHORIZED REPRESENTATIVE FOR THE DISPUTED CLAIMS PROCESS

Name of BCBS FEP Dental Member:

_____

Name of Person Granting Authorization and Relationship to BCBS FEP Dental Member (e.g., parent, personal representative, same as above if BCBS FEP Dental member):

_____

I designate the following provider _____[***insert name of dental provider***] as my authorized representative to appeal the claims decision listed below:

This authorization is for the sole purpose of allowing 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 _____

_____

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

I authorize the BCBS FEP Dental **to release** protected health information including all medical records, medical rationale, or relevant reference materials the BCBS FEP Dental utilized in making their adverse benefit determination to my authorized representative.

I authorize the following individuals or organization **to receive** my protected health information, including all medical records, medical rationale, or relevant reference materials the BCBS FEP Dental utilized in making their adverse benefit determination.

_____

[Insert the name of the person or organization authorized to receive your protected health information]

[1] Protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care 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 health care to me.

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

_____

_____

_____

*[Describe in **as much detail a 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 BCBS FEP Dental Member Services at PO Box 75, Minneapolis, MN 55440-0075 and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective for the 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.