APPOINTMENT OF REPRESENTATIVE (AOR) FORM

Name of person you are appointing as an Authorized Representative: _____

Relationship to covered person: ☐ **Relative** ☐ **Healthcare Provider**

☐ **Attorney** ☐ **Other _____**

Contact information of authorized representative
Mailing Address:
Daytime Phone:
Email Address: **Fax:**

Covered Person Information
Name: **ID Number:**
Mailing Address:
Phone:
Email Address: **Fax:**

Appointment of Authorized Representative (Purpose: To grant permission for another individual or company to act on your behalf in filing a Grievance or Appeal). You may revoke this authorization at any time.

I, _____ (Member Name), appoint _____ (Name of Authorized Representative), to act on my behalf in connection with any claim for coverage or benefits identified in this case, including receipt of any approval(s) or authorization(s) that are required before medical service(s). I authorize my representative to receive any and all information related to this case that is provided to me and to provide any information to the health plan in relation to the disputed claims, approvals, or authorizations. This information may include, a diagnosis (name of illness or condition), claims, doctors and other health care providers and financial information (like billing and banking). I also understand that I may revoke (or cancel) this approval at any time. I understand that I cannot cancel this approval when this form has already been used to disclose information.

Expiration: This consent is valid for one year from the date of this signed form unless you withdraw in writing sooner than one year.

I have read the contents of this form. I understand, agree, and allow CareSource to the use and release of my information as I have stated above. I also understand that signing this form is of my own free will. I understand that CareSource does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits. I have the right to withdraw this approval at any time by giving written notice of my withdrawal to CareSource.

I understand that my withdrawing of this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Signatures:

_____

Signature of Covered Person (or legal representative*) Date: _____
***Parent, Guardian, Conservator, Other please specify**

I, _____ (Name of Authorized Representative),

hereby accept the above appointment. I am a/an _____ (Relationship to Member).

_____

Signature of Authorized Representative _____ Date _____

Designated Legal Representative/Guardian:
If this form is signed by someone other than the member or parent, such as a personal representative, legal representative or guardian on behalf of the member, please submit the following:

- ❒ **A copy of a health care, general or Durable Power of Attorney.**
  OR
- ❒ **A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.**

SEND THIS FORM AND A COPY OF YOUR NOTICE OF ADVERSE BENEFIT DETERMINATION TO ONE OF THE FOLLOWING:

Mailing Address: CareSource, Attn: Member Appeals, P.O. Box 1947, Dayton, OH 45401-1947

If you need help with this form, you may call the Member Services department at 1-833-230-2099 (TTY: 711), Monday through Friday, 7 a.m. to 7 pm Eastern Time.

NC-Multi-EXC-M-2073310