APPOINTMENT OF REPRESENTATIVE (AOR) FORM

Member Information

Member Name: ID Number:

Mailing Address:

Email Address: Phone:

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), authorize _____ (name of person you are appointing as an 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 authorization 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 revoke authorization in writing to the address listed below sooner than one year. Mailing address:

CareSource
Attn: Grievance and Appeals
Department
P.O. Box 1947
Dayton, OH 45401-1947

Signature of Member (or legal representative*): Date:
Printed name of legal representative:
*Legal Representative: ☐ Parent ☐ Guardian ☐ Conservator ☐ Other (please specify):
☐ I have read the contents of this form. I understand, agree, and allow CareSource to use and release of my information as I have stated in this form. 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 revoking of this authorization will not affect any action taken before I do so. I also understand that information that's released to my authorized representative may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Designated Legal Representative/Guardian of Member:

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.

AUTHORIZED REPRESENTATIVE:

Signature of Authorized Representative:	Date:

Printed name of Authorized Representative:

Relationship to Member (please specify):

☐ Relative ☐ Health Care Provider ☐ Attorney ☐ Other:

☐ I hereby accept the above appointment of authorization to act on behalf of this member in this case.

Contact Information:

Daytime Phone: Fax:

Email:

Mailing Address:

SEND THIS FORM AND A COPY OF YOUR NOTICE OF ADVERSE BENEFIT DETERMINATION, ALONG WITH DOCUMENTATION OF THE DESIGNATED LEGAL REPRESENTATIVE WHEN APPROPRIATE, TO THE FOLLOWING **MAILING ADDRESS:**

CareSource
Attn: Grievance and Appeals Department
P.O. Box 1947
Dayton, OH 45401-1947

If you need help with this form, call Member Services at **1-877-514-2442** (TTY: 711). We're here Monday through Friday from 8 a.m. to 5 p.m. Central Time (CT).

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