Providence
Health Plan
P.O. Box 4327
Portland, OR 97208-4327
ProvidenceHealthPlan.com

# AUTHORIZED REPRESENTATIVE FORM – COMMERCIAL APPEALS & GRIEVANCES

**Member Information:** (Please provide the following information)

| | |
|---|---|
| **First Name:** | **Last Name:** |
| **Address:** | **City & State:** |
| **Phone** (with area code)**:** | **Email:** |
| **Date of Birth** (mm/dd/yyyy)**:** | **Member ID #** |

I appoint _____
**Print Name of Representative (Individual)** **Mailing Address** **Relationship**

to act on my behalf as my authorized representative for the purpose of requesting an appeal for coverage, payment of a claim or to file a complaint on my behalf.

**Member Signature: _____ Date: _____**

## Authorization to Release Health Information for Appeals, Claims or Grievances

By signing above, I understand and agree to the following:

- I authorize Providence Health Plan and its subsidiaries to disclose to the above named representative any information relevant to my grievance, claim or appeal, including, but not limited to, medical records and coverage information.
- My Authorized Representative may exhaust my formal appeal rights and will receive all communication regarding any such appeal or grievance in lieu of me.
- This authorization shall begin the date I sign this form and will remain in effect until my administrative appeals are exhausted, and no longer than 12 months.
- I understand that I may revoke or cancel this authorization at any time by sending PHP a written cancellation statement at the mailing address listed below. My cancellation of this authorization will not affect any action PHP took before it received my request.

Specific authorization is required to release medical and financial information concerning the health care information listed below. By initialing, I authorize release of the information related to my appeal, claim or grievance relating to examination, testing, diagnosis or treatment for the following forms of sensitive information:

_____ Alcohol/Drug/Substance Use Disorder
Initials

_____ Mental Health
Initials

_____ HIV/STD/STI/AIDS
Initials

_____ Maternity/Pregnancy (Reproductive Care-Health)
Initials

_____Genetic Information
Initials

- Note: To parents/legal guardians of minors: state laws may prohibit Providence Health Plan from acting on your request about Sensitive Information without written authorization from the minor member. (Both Representative and minor must sign).

**Representative Signature: _____ Date: _____**

Submit this completed form to Providence Health Plan: Appeal & Grievances, PO Box 4158, Portland OR 97208