NYS Standard Form to Designate a Representative to Assist with Health Insurance* Authorizations, Complaints, Grievances, and Appeals

SECTION 1: MEMBER AND CLAIM INFORMATION			
Member Name:			**Date of Birth:**
Address:			**Email (optional):**
City:	**State:**	**Zip:**	**Home phone #:** **Cell phone #:**
Insurer Name:		**Member ID:**	
Claim # (if applicable):		**Group # (if any):**	
Description of Claim/Services/Items Denied or to be Requested:			

SECTION 2: DESIGNATED AUTHORIZED REPRESENTATIVE

I, _____(print name), designate the person or persons or organization identified below to be my authorized representative to help me file and assist me with a preauthorization request, complaint, grievance, or appeal to my insurer, and to request and receive information related to the preauthorization request, complaint, grievance, or appeal for the claim, services, or items described above.

Name(s):		**Organization:**	
Address:			
City:	**State:**	**Zip:**	**Phone #:**
Relationship to Member (if any):		**Email:**	

SECTION 3: END DATE OF AUTHORIZATION

This Authorization ends on ____/____/_____(month) (day) (year)

OR

upon the following event: _____.

I understand that if I don't include an end date or event, this authorization will remain in effect until I cancel it in writing, the resolution of the preauthorization request, complaint, grievance, or appeal, or 24 months from the date I signed this form, whichever occurs first.

SECTION 4: CONDITIONS OF AUTHORIZATION

I understand that:

- This authorization is voluntary.
- My insurer will not condition my enrollment, eligibility, or payment of a claim for health benefits on my provision of this authorization.
- My health information may be subject to re-disclosure by my designated representative, and if my designated representative is not a health care provider, the information may no longer be protected by federal or state privacy laws and regulations.
- I have the right to cancel this authorization at any time, and that the cancellation must be in writing. (Send written notice to the address or fax number on your ID card or specified by your insurer.)
- Any cancellation will take effect as soon as my insurer receives my written notice of cancellation. I understand that the cancellation will not affect any action taken by my insurer in reliance on the authorization before receiving my written notice of cancellation.

SECTION 5: SIGNATURE

_____	_____
Signature	Date
_____	_____
Print Name	Relationship to Member (if Member is not signing)

If you are signing as power of attorney, legal guardian, or other legal representative, please provide a copy of documentation of your legal authorization with this form.

* Health Insurance includes: comprehensive health insurance, vision insurance, and dental insurance.

Important:

- This form may be used by enrollees with Medicaid managed care, Essential Plan, and Child Health Plus coverage. This form is NOT intended for use by members with other Medicaid coverage or Medicare. Please contact your insurer/health plan to obtain a form for that coverage, if required.

- This form may not be sufficient to release certain sensitive health information that is protected by state or federal law. Your insurer may ask you to complete a separate authorization to release sensitive information, such as mental health, substance use disorder, or HIV/AIDS information.

- If you filed an internal appeal and it was denied by your insurer, you may have the right to an external appeal. You may appoint a designee to file your external appeal. Do NOT use this form to appoint a designee for filing an external appeal. Information on filing an external appeal can be found at: www.dfs.ny.gov/complaints/file_external_appeal

This form should be submitted to: the address or fax number on your member identification card.