Member Authorization Form for a Designated Representative to Appeal a Determination

To: **United Healthcare**
P.O Box 30432
Salt Lake City, UT 84130-0432

Date: _____

Member Name: _____

Member #: _____

I hereby authorize _____ to appeal United Healthcare's determination concerning _____ on my behalf, as my Designated Representative, and, as part of the appeal, I hereby authorize United Healthcare in its decision letter and in connection with the processing of my appeal, to communicate with my Designated Representative in all aspects of the appeal. I understand that these communications may contain the following:

> **All medical and financial information contained in my insurance file, Including but not limited to treatment for venereal disease, alcoholism and drug abuse, abortion, mental disorder and HIV status relating to my examination, treatment and hospital confinement in connection with the determination which is being appealed.**

I understand this information is privileged and confidential and will only be released as specified in this Authorization, or as required or permitted by law. This authorization is valid for a period of one year.

_____
Signature of Member or Legal Guardian/Representative

_____
___ Signature of Witness ___ Designated Representative (Check one)

_____
Name of witness/ Designated Representative (Please print)

_____
Title (if on provider's staff) or Relationship to Member