# EMI Health
# Claims Appeal
# Appointment and Authorization of Representative

I, _____ (name of covered person), state that I have sufficient mental capacity to understand this Appointment and Authorization and do hereby sign of my own free will and choice. I hereby appoint _____ (name of authorized representative) to act on my behalf (name of patient/minor or disabled covered person) in connection with _____ (description of specific claim for coverage or benefit(s) being appealed). I understand that this authorization will allow the named representative to settle my claim and may result in me personally owing money to health care providers or I may be responsible to reimburse EMI Health for improperly paid claims.

**HIPAA Authorization and Disclosure:**

Purpose of Disclosure: To allow an appointed and authorized representative to receive and use all information for me including Personal Health Information (PHI) as defined by HIPAA.

I understand that:

1. Once EMI Health discloses information according to this Authorization, it cannot guarantee that this information will not be redisclosed to a third party or that this information will be protected by federal and state law governing the use and disclosure of individually identifiable health information.

2. This Authorization will remain in effect until the end of the appeal or until I provide a written notice of revocation to EMI Health.

3. I may refuse to sign or may revoke this Authorization at any time for any reason, except to the extent that EMI Health has already made disclosures in reliance on this Authorization; and

4. While EMI Health does not condition the commencement, continuation or quality of health insurance, care management, and other services it provides to me on my signing and not revoking this Authorization, my refusing to sign or revoking this Authorization may limit EMI Health's ability to proceed with this appeal.

In understanding of this Authorization, I agree to allow EMI Health to disclose my information as described in this Authorization. If I have questions about such disclosures, I can contact EMI Health at 1-800-662-5851 or locally at 262-7475.

This Authorization to disclose PHI is valid until the end of this appeal or until revoked, in writing. Revocation will be valid only for future acts and will not be valid for any action EMI Health has taken before receiving a written revocation.

I authorize my representative to receive any and all information related to this appeal including PHI that is provided to me and to act on my behalf in providing any information to the Plan that relates to this claim for coverage or benefits under the Plan. This authorization is limited to this appeal and will be terminated at the end of the appeals process if not terminated sooner in writing.

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| Covered Person's Signature | Date |
| Accepted: Authorized Representative | Date |

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