blue california

Promise Health Plan

APPOINTMENT OF REPRESENTATIVE

Use this form to authorize Blue Shield of California, Blue Shield of California Life & Health Insurance Company, and their business associates (collectively "Blue Shield") to allow an appointment of representation in connection with my appeal or grievance. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance or request wholly in my stead. I understand that personal medical information related to my request may be disclosed to the representative indicated below.

1. Person appointing a representative ("Member")

Member name:

Member address:

Subscriber ID number:

Date of birth:

2. Who is the appointed representative?

Recipient's name:

Recipient's address:

Recipient's relationship to the Member:

3. What is the purpose of completing this form? (Check one)

☐ Appoint a representative

☐ Revoke an existing appointment of representative

4. Expiration and revocation.

This Appointment of Representation will remain in effect for one year from the date you sign it (below) unless a different date is specified here: ____/_____/_____

You have the right to revoke this Appointment of Representation at any time by notifying Blue Shield Promise Health Plan in writing. *Revoking this Appointment of Representation will not affect Information we use or disclose before we receive your revocation request.* If this Appointment of Representation is given by a parent or legal guardian on behalf of a minor, it will expire on the minor's eighteenth birthday.

5. Signature of member and representative

I have read this form and I understand and agree to its terms. I direct Blue Shield Promise Health Plan to allow an appointment of representation and use or to disclose the Information to the noted recipient as directed above. This may include health information like substance abuse, mental health, behavioral health, genetic testing, and HIV/AIDS status. I understand that once my information is disclosed, it could be re-disclosed by the recipient and may no longer be protected by privacy laws, including the federal Health Insurance Portability and Accountability Act of 1996.

I understand that Blue Shield Promise Health Plan may not condition payment, enrollment in a health plan, or eligibility for benefits on whether I sign this Appointment of Representation.

Member signature _____ Date _____

Member's name (print) _____

By signing below, I have read this form and hereby accept the above appointment.

Representative signature _____ Date _____

Representative's name (print) _____

Legal representatives or guardians

If this form is signed by someone other than the Member or the parent of a minor, such as a personal/legal representative, guardian, or executor, **you must also submit legal documentation** showing your authority to act on behalf of the Member (or the Member's estate) to appoint a representative. Such documentation may include, for example:

1. Durable Health Care Power of Attorney
2. Current, valid documentation of court- ordered guardianship; or
3. Other valid legal documentation showing your authority to act on behalf of the Member (or the Member's estate).

Representative's name (print):

Relationship to Member:

Type of documentation submitted:

Keep a copy of the Appointment of Representative form for your records

Return the completed and signed appointment of representative form to:

Blue Shield of California Promise Health Plan Privacy Office
P.O. Box 272540
Chico, CA 95927-2540