



**Collective
Health**

Collective Health
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Appointment of Authorized Representative
Under the Group Health Plan's Claims and Appeals Procedures

I, _____ **[name of group health plan participant]** hereby appoint
_____ **[name of Authorized Representative]** ("Representative") to act
on my behalf or on behalf of _____ **[name of patient if minor and
dependent of group health plan participant]** in connection with the claim(s) for coverage or benefits or
appeal of an adverse benefit determination from _____ **[name
of medical service provider]** ("Provider") for dates _____ **[date(s) of service]** under
the group health plan ("Plan") in which I am a member. I authorize my Representative to receive any and
all information requested by such Representative pursuant to the Plan's claims procedures with regard to
the services rendered by Provider for such dates indicated above, and to act for me and for my
dependent, if named above as the patient, in providing any information to the Plan that relates to any
claim for coverage or benefits under the Plan or for the appeal of an adverse benefits determination under
the Plan. I understand that personal medical information related to my request may be disclosed to the
Representative.

Assignment of benefits is prohibited under the Plan. This appointment of authorization supersedes any
existing authorization or assignment of rights and interests by and between me (on behalf of myself or my
dependent named above) and the Provider or its agents and representatives. Any other authorization or
assignment of rights and interests will be deemed null and void. This appointment of authorized
representative will not be effective until fully executed and dated below.

IMPORTANT: All information and notifications relevant to the services rendered by Provider, and
provided under the Plan's claims procedures, on the above indicated dates from the Plan will be directed
to the Authorized Representative appointed through this form and not to you. If you would also like a copy
of the appeal determination letter, please call the Collective Health phone number listed on your medical
ID card for further assistance.

Claimant Signature Date

Authorized Representative Signature Date