550 N. Meridian Street, Suite 101
Indianapolis, IN 46204

Member Authorization for a Designated Representative to Appeal a Determination

To: MHS Appeals
PO Box 441567
Indianapolis, IN 46244
Fax: 1-866-714-7993

Member Name: _____

Member ID #: _____ Date: _____

I hereby authorize (print name) _____ to appeal the Managed Health Services (MHS) determination concerning:

(description of service) _____

(date of MHS' determination or reference number) _____ on my behalf, as my Designated Representative, and, as part of the appeal, I hereby authorize MHS in its decision letter and in connection with the processing of my appeal, to communicate with my Designated Representative concerning the following:

> All medical and financial information contained in my insurance file, including all treatment, examination, outpatient 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. This authorization is valid for a period of one year. Your provider shall not charge you for serving as your representative to this appeal.

Member or Parent/Legal Guardian/Representative Signature: _____

Parent, legal guardian, or representative relationship: _____

Signature of Witness: _____

Name of Witness: _____ Date: _____

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The witness listed was present when the member designated the individual listed to represent the member at the member's appeal.
This appeal concerns whether MHS will pay for treatment requested by your provider. As an MHS member, your right to appeal is not contingent on choosing your provider to appeal a determination.
You may cancel this agreement by writing to MHS Appeals at the address listed at the top of this form.
Your healthcare information related to this service appeal will be shared with people that will hear your appeal or manage the appeals process.