

APPOINTMENT OF REPRESENTATIVE

Member Name

Member Number

SECTION 1: Appointment of Representative *(To be completed by the party seeking representation)*

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.

If the member can't sign this form, a legal representative may sign, complete, and return this form on behalf of the member. A legal representative is someone who has the legal right to sign for the member. Please attach proof that you are the member's legal representative (for example, Power of Attorney). We can't accept this form without it.

Signature of Member *(Party Seeking Representation)*

Date

Street Address

Phone Number

City

State

Zip Code

Email Address

Fax Number

SECTION 2: Acceptance of Appointment

Full Name

Relationship to Member

Date

Street Address

Phone Number

City

State

Zip Code

Signature of Representative *(Appointee)*

Email Address

How long does this permission last?

In most cases, permission to share your personal health information ends on your last day as a plan member or you write to us and tell us to end it.

Where to mail this form:

Alterwood Advantage
Attn: Enrollment Department
10090 Red Run Blvd, 2nd Floor
Owings Mills, MD 21117

Where to email this form:

memberservices@alterwoodhealth.com

Or, fax to: 1-410-801-5866

Questions?

Call Customer Service 667-262-9412 or 1-866-675-3944 toll-free (TTY: 711)

8 am – 8 pm ET | 7 days a week | October 1 – March 31

8 am – 8 pm ET | Monday – Friday | April 1 – September 30