



APPOINTMENT OF REPRESENTATIVE

As a Priority Health Medicare Plan member, you may appoint any individual (such as your spouse, or a relative, friend, advocate, attorney or any physician) to act as your representative to assist you with understanding and following issues such as coverage determinations, exceptions, appeals or grievances. Priority Health Medicare must have written authorization from you to discuss these issues with that person. If you appoint a representative on your behalf, you are granting that person the right to represent you. **Please understand you are agreeing to allow this person access to private health information related to your Medicare issue.**

If you wish to appoint an individual as your representative, please send us a completed **Appointment of Representative** form (attached). The form must be signed, dated and completed by both you and your representative. The Appointment of Representative form will be valid for a period of one year from the date it is completed.

Please note: A representative who is appointed by the court or who is acting in accordance with state law also may file a request on your behalf and must send us appropriate legal papers demonstrating she or he is your legal representative. If this other documentation is provided, you will not need to complete an Appointment of Representative Form.

How to Complete the Appointment of Representative Form OMB 0938-0950

Section I:

You, the member, complete Section I:

1. Fill in your name, if you are the member who is appointing the representative.
2. Fill in your member ID number, from your Priority Health Medicare Plan ID card.
3. Fill in the name of the person you want to be your representative. **Please understand you are agreeing to allow this person access to private health information related to your Medicare issue.**
4. Sign your name in the Signature of Beneficiary box.
5. Enter the date of your signature.
6. Enter your address and phone number.

Section II:

Your representative completes Section II:

1. Your representative fills in Section II, starting with his/her full name.
2. Your representative fills in his or her professional status (such as attorney) or relationship to you (such as relative).
3. Your representative signs his/her name.
4. Your representative enters the date of the signature.
5. Your representative enters his/her address and phone number.

Section III:

- Your representative may be someone you employ to represent you, and therefore it may be appropriate for him or her to charge a fee (such as an attorney). In this case, he/she will not sign Section III.
- If your representative wishes to waive the fee or must do so, he/she must sign and date the statement in this section.
 - If your provider (your doctor) or supplier (for the items in your current Medicare Plan) is your representative, he/she she can NOT charge a fee and must sign and date Section III.

Section IV:

- If your representative is not your provider or supplier, he/she will not sign Section IV.
- If your representative is your provider or supplier, he/she must sign and date Section IV, to agree that payment is dependent upon resolution of your issue if it may be related to a service provided or supplied to you by the provider or supplier.

When you and your representative have completed this form, please send it to:

Priority Health Medicare
Attention: Customer Service, MS 1115
1231 East Beltline, NE
Grand Rapids, MI 49525
Fax: (616) 942-0995

APPOINTMENT OF REPRESENTATIVE

NAME OF PARTY	MEDICARE OR NATIONAL PROVIDER IDENTIFIER NUMBER
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SECTION I: APPOINTMENT OF REPRESENTATIVE

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint this individual: _____ to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. 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 appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

SIGNATURE OF PARTY SEEKING REPRESENTATION		DATE
STREET ADDRESS		PHONE NUMBER (with Area Code)
CITY	STATE	ZIP

SECTION II: ACCEPTANCE OF APPOINTMENT

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____
(PROFESSIONAL STATUS OR RELATIONSHIP TO THE PARTY, E.G. ATTORNEY, RELATIVE, ETC.)

SIGNATURE OF REPRESENTATIVE		DATE
STREET ADDRESS		PHONE NUMBER (with Area Code)
CITY	STATE	ZIP

SECTION III: WAIVER OF FEE FOR REPRESENTATION

Instructions: This section must be completed if the representative is required to, or chooses to waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of the Department of Health and Human Services.

SIGNATURE	DATE
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SECTION IV: WAIVER OF PAYMENT FOR ITEMS OR SERVICES AT ISSUE

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

SIGNATURE	DATE
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CHARGING OF FEES FOR REPRESENTING BENEFICIARIES BEFORE THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of the Department of Health and Human Services (DHHS) (i.e., an Administrative Law Judge (ALJ) hearing, Medicare Appeals Council (MAC) review, or a proceeding before an ALJ or the MAC as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR §405.910(f).

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing or request for MAC review

Approval of a representative's fee is not required if (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation.

AUTHORIZATION OF FEE

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before DHHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, the ALJ or MAC considers the nature and type of services performed, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

CONFLICT OF INTEREST

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.

WHERE TO SEND THIS FORM

Send this form to the same location where you are sending (or have already sent) your appeal if you are filing an appeal, grievance if you are filing a grievance, initial determination or decision if you are requesting an initial determination or decision.

If additional help is needed, contact your Medicare plan or 1-800-MEDICARE (1-800-633-4227).

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.
