

## Designation of an Authorized Representative

This Section To be completed by the Customer Service Representative Only

To: (check one)

Member Grievance and Appeals  
P.O. Box 2717  
Pittsburgh, PA 15230-2717  
Attention: Grievance Review Committee

Member Grievance and Appeals  
P.O. Box 535095  
Pittsburgh, PA 15253-5095  
Attention: Review Committee

Highmark Blue Shield  
P.O. Box 890178  
Camp Hill, PA 17089-0178  
Attention: Review Committee

Highmark Blue Shield  
P.O. Box 890174  
Camp Hill, PA 17089-0174  
Attention: Grievance Review Committee

Member Name: \_\_\_\_\_ Member's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Identification Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Claim Number (if applicable): \_\_\_\_\_

Description of services/items denied: \_\_\_\_\_

I, \_\_\_\_\_ do hereby authorize Highmark Inc., to disclose the above  
(Member Name)  
information to \_\_\_\_\_,  
(Name of Representative)  
of \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
(Address of Representative) (Telephone No. of Representative)

as my representative to participate in the:  Appeal  Complaint  Grievance

process on my behalf.

I understand that, if the persons or organizations I authorize to receive and/or use the protected health information described above are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

I understand that Highmark may condition payment of a claim for specified benefits on my signing of this authorization (other than for psychotherapy notes) to allow other covered entities to disclose protected health information to Highmark that Highmark needs to determine payment of my claim.

Highmark Inc., its subsidiaries, affiliates, employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

**If you are consenting to permit your health care provider to file an Act 68 Grievance on your behalf, please also complete and sign page three (3) of this form.**

Description of scope of representative's authority:

- Represent member's interest in First Level Review
- Represent member's interest in Second Level Review
- Represent member's interest in all possible appeals
- Other (*specify*): \_\_\_\_\_

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Unless otherwise revoked, this authorization will expire on the following date, event, or circumstance:  
***(Insert date, event, or circumstance---if no date, event or circumstance is included, this Authorization will expire one year after date of member signature)***

Expiration Date: \_\_\_\_\_

I understand that I have the right to revoke this designation at any time. Such revocation shall only become effective upon receipt by Highmark, Inc. of notice of my revocation.

Member's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**You are entitled to a copy of this authorization after you sign it.**

**Complete for Act 68 grievances only when provider is acting on member's behalf:**

Health Care Provider Number: \_\_\_\_\_

**I understand that if my health care provider files a grievance on my behalf, I cannot file a grievance for the same issue unless I rescind my consent in writing. I have the right to rescind my consent in writing at any time during the grievance process. In the event that my health care provider fails to file or pursue a grievance through the second level grievance process, this consent shall be deemed as having been automatically rescinded without further action on my part.**

**Once a health care provider assumes responsibility for filing a grievance, the health care provider may not bill the enrollee or the enrollee's legal representative for services provided that are the subject of the grievance until the external grievance review has been completed or the enrollee or the enrollee's legal representative rescinds consent for the health care provider to pursue the grievance.**

**If the health care provider elects to appeal an adverse decision of a CRE (Certified Review Entity), the health care provider may not bill the enrollee's legal representative for services provided that are the subject of the grievance until the health care provider chooses not to appeal an adverse decision to a court of competent jurisdiction.**

I have read, or have been read this consent form, and have had it explained to my satisfaction. I understand the information in the consent form.

**Member or Member's Legal Representative:  
(If member is a minor or legally incompetent)**

\_\_\_\_\_  
Signature Date

Relationship to member \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Witness:**

\_\_\_\_\_  
Signature Date

**Note: A health care provider may not require member/member's legal representative to sign a document authorizing the health care provider to file a grievance as a condition of providing a health care service.**