

**Member Authorization Form for a Designated Representative to Appeal a Determination**

DATE: \_\_\_\_\_

Member Name: \_\_\_\_\_

Member #: \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to appeal UnitedHealthcare's determination concerning:

\_\_\_\_\_  
\_\_\_\_\_

on my behalf, as my Designated Representative, and, as part of the appeal, I hereby authorize UnitedHealthcare in its decision letter and in connection with the processing of my appeal, to communicate with my Designated Representative in all aspects of the appeal. I understand that these communications may contain the following:

All medical and financial information contained in my insurance file, including but not limited to treatment for venereal disease, alcoholism and drug abuse, abortion, mental disorder and HIV status relating to my examination, 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, or as required or permitted by law. This authorization is valid for a period of one year.

\_\_\_\_\_  
Signature of Member or Legal Guardian/Representative

\_\_\_ Signature of Witness      \_\_\_ Designated Representative (Check one)

\_\_\_\_\_  
Name of Witness/Designated Representative (Please Print)

\_\_\_\_\_  
Title (if on provider's staff) or Relationship to Member