Appointment of Representative for an Appeal

PRIVACY ACT STATEMENT

This statement serves to inform you of the purpose for collecting personal information required by Health Net Federal Services, LLC (Health Net) on behalf of the TRICARE program, and how it will be used.

AUTHORITY: 10 U.S.C. Chapter 55; 38 U.S.C. Chapter 17; 32 CFR Part 199, and E.O.9397 (SSN), as amended.

PURPOSE: To appoint a representative to act on your behalf at any level of the appeal process.

ROUTINE USES: Your information may be disclosed in order to investigate waste, fraud and abuse, security, and privacy concerns. Use and disclosure of your records outside of DoD may occur in accordance with the DoD Blanket Routine Uses published at http://dpclo.defense.gov/privacy/SORNs and as permitted by the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)). Any protected health information (PHI) in your records may be used and disclosed as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), and includes purposes of treatment, payment, and health care operations.

DISCLOSURE: Voluntary; if you choose not to provide your information, no penalty may be imposed, but absence of the requested information may result in administrative delays or the inability to process an individual's request.

This form allows a beneficiary to appoint someone to act on their behalf regarding a TRICARE appeal (32 CFR 199.10 – Appeal and Hearing Procedures). This form is not required if you are submitting an appeal for yourself or for a minor dependent. This appointment only applies to the denial(s) indicated below and the related authorization and/or claims.

Please note: You may not appoint an employee of the federal government, such as a military service member, military treatment facility provider, health benefits advisor, or an employee of a uniformed service, unless the representative is an immediate family member.

Beneficiary (patient) name: _____ Sponsor SSN: _____ Beneficiary DBN: _____

Denied authorization number(s) or claim number(s):

_____ _____

I appoint the following person to act as my representative in appealing the above services. I also authorize the Defense Health Agency and its delegates to release to the following representative, information related to my medical treatment, and if necessary, photocopies of any medical records which may be required for processing the above TRICARE claims or authorizations.

Name of representative: _____

Representative street address: _____

City, State, ZIP code: _____

I understand an appeal determination letter will be sent to the representative and will constitute (be the same as) notification of the determination to me.

This consent will expire upon the issuance of the final agency decision regarding my appeal; however, I reserve the right to withdraw this appointment at any time.

_____ _____

(Signature of person giving consent) (Date)

_____

(Printed name of person giving consent)

This form should be submitted with the appeal. However, if you do not submit this form with the appeal you may fax the form to 1-844-769-8007 or mail it to PO Box 2219, Virginia Beach, VA 23450-2219.

Prohibition on redisclosure: Further disclosure of information by the appointed representative may only be made in accordance with the provisions of the Privacy Act of 1974, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and other applicable federal law.