APPOINTMENT OF REPRESENTATIVE FOR HEALTH PLAN APPEAL

KAISER PERMANENTE®

Date: **Member number:**

Name: **Reference/Case number:**

PART 1 --- APPOINTMENT OF REPRESENTATIVE (to be filled out by Member)

I allow _____ to act for me when filing a
(Name of person you want as your representative)
grievance, claim or appeal with my health plan.

The person I have named can act for me when giving or receiving any information about my grievance, claim or appeal with my health plan. This includes personal medical information.

Member:	Date:
Street Address:	Telephone (with area code):
City:	State: ZIP Code:

For an appeal with the Department of Human Services' Administrative Appeals Office (AAO), additional forms are required. Only members or Authorized Representatives are allowed to request a hearing with AAO Under HAR §17-1703 1-3(c) and 42 CFR §438.402(c)(1)(ii), a provider or authorized representative can file an appeal for a member if the member gives written consent.

PART 2 --- ACCEPTANCE OF APPOINTMENT (to be filled out by Members' Representative for Health Plan appeal)

_____ , accept the appointment. I will
(Name of person who will be member's representative)
act on behalf of the member to file a grievance, claim or appeal.

Relationship to Member: (Must be age 18 or older)	
Representative Signature:	Date:
Street Address:	Telephone (with area code):
City:	State: ZIP Code:

This authorization is good for one year from the date you sign this form unless you tell us the following:
Date: _____/_____/_____Or Event: _____

Month Day Year

Part 3 ---YOUR INDIVIDUAL RIGHTS (Please read):

I understand that:

- I do not have to sign this form.
- I can cancel this form by writing to Kaiser Permanente at the address below except for the information that was already disclosed.
- Once my protected health information is disclosed to the person or organization I specified in **Part 1** of this form, the information in their possession may no longer be protected by privacy laws.

Member Signature: _____ Date: _____

After completing this form, please mail, fax, or deliver this form to the address below:

Kaiser Permanente
Hawaii Grievance and Appeals Operations
711 Kapiolani Blvd
Honolulu, HI 96813
Toll-free: 800-966-5955
TDD/TTY: 711
Fax: 808-432-5260