Allegiance℠
Life & Health Insurance Company

Authorization to Appeal Adverse Benefit Determination

INSTRUCTIONS:
Use this form to appoint an authorized representative to act for the Claimant in connection with a claim for benefits or an appeal of an adverse benefit determination, and to receive protected health information in connection with the representation. Complete and mail this form to the Third Party Administrator: Allegiance Benefit Plan Management, Inc. P.O. Box 3018, Missoula, MT 59806-3018

1. Identify Employee or Former Employee Who Is or Was Covered by Allegiance Life & Health

Print Name of Employee:	Address of Employee:

2. Identify Claimant (Person for Who Received Medical Service or Supplies)

☐ Employee ☐ Employee's Spouse ☐ Employee's Child ☐ Other (explain)

Print Name of Claimant:	Address: ☐ Employee's address above ☐ Different address (provide address)

3. Identify Authorized Representative of Claimant

Name of Authorized Representative	Address:	
Telephone:	Fax:	Email:

4. Designate Representation With Respect to Claim or Appeal

The Authorized Representative will represent Claimant with respect to *(check all that apply)*:
☐ a benefit claim ☐ an appeal of a denied benefit claim

5. Describe Claim

Describe the benefit claim for which Authorized Representative is representing Claimant *(use claim number, date of service or similar information to describe claim)*:

6. Does Claimant Receive Information and Notifications from Allegiance Life & Health?

All information and notifications regarding the Claim will be directed to the Authorized Representative and not to Claimant unless you check the box below:
☐ Direct information and notification regarding the Claim to Authorized Representative and to Claimant

7. Appoint Representative and Authorize Disclosure of Protected Health Information

Appointment. Claimant appoints Authorized Representative to represent Claimant with respect to the Claim described above.

Authorization. Claimant authorizes Allegiance Life & Health Insurance Co., and its Third Party Administrator to disclose to Authorized Representative any and all personal health information of Claimant relating to the Claim. I understand:

Claimant may receive a copy of this signed authorization if Claimant asks for it.

Claimant is not required to sign this form to receive health care benefits (enrollment, treatment, or payment).

Authorized Representative may re-disclose the information that is used or disclosed pursuant to this authorization.

This Authorization is effective only if signed by Claimant, Claimant's personal representative or the parent or legal guardian of Claimant who is a minor. A personal representative must provide satisfactory evidence of their status as personal representative.

8. Set Termination

This Appointment and Authorization expires upon *(optional, check one and complete)*:
☐ (Event) _____ ☐ (Date) _____

Clamant may revoke this Appointment and Authorization at any time by notifying Third Party Administrator in writing, but the revocation will not have any effect on any actions that Allegiance Life & Health or its Third Party Administrator took before Third Party Administrator received the revocation.

Signature	Print Name	Date
I am the: ☐ Claimant ☐ Claimant's parent ☐ Claimant's guardian ☐ Other (explain):		Telephone Number

9. Authorized Representative's Acceptance

I accept my appointment as Authorized Representative of the Claimant.

Signature	Print Name	Date