DESIGNATION OF PERSONAL REPRESENTATIVE FOR APPEAL PURPOSES

INSTRUCTIONS: The attached form is used to designate a Personal Representative for purposes of an appeal of a denial (or reduction) of benefits. The Personal Representative may be a family member, friend or any other person you choose to designate. BCBSD will treat the person that you name in this form in the same manner that we would treat you for purposes of the appeal. That means that we will provide all relevant information, including your Protected Health Information, to that individual, and will allow that person to act on your behalf.

PLEASE NOTE THE FOLLOWING:

1. **Minor Children (under 18)**
   Parents are generally considered to be the personal representatives for their minor children. If the appeal concerns services rendered to a minor child, you do not need to complete this form. There are certain exceptions to this rule and we will contact you if a Personal Representative Form must be completed.
2. **Children Over 18**
   If the appeal concerns services rendered to a child over 18, the child must complete this form if his or her parent will be handling the appeal.
3. **Guardianships**
   If the appeal concerns services rendered to a person who has a Legal Guardian, this form must be completed by the Legal Guardian. Please submit proof of the guardianship with this form.
4. **Power of Attorney**
   If the appeal concerns a claim for service rendered to a person for whom there is a Power of Attorney, the Attorney must complete this form. Please submit a copy of the Power of Attorney with this form.

   Please provide ALL requested information, and sign and date the form. We will return incomplete forms, and will not recognize your representative until all information has been provided.

   Please call Customer Service at (   ) ____________________ if you have any questions.

Please keep a copy for your records and mail or fax this form to:

Blue Cross Blue Shield of Delaware
Customer Service
PO Box 1991
Wilmington, DE 19899-1991

Fax # (   ) __________________________

Blue Cross Blue Shield of Delaware is an independent licensee of the Blue Cross and Blue Shield Association.

BlueCross BlueShield of Delaware

DESIGNATION OF PERSONAL REPRESENTATIVE FOR APPEAL

■ **SECTION A. Appellant (Member) Information. (Please identify the person whose claim is being appealed.)**

Last name:___________________________________ First name: ______________________________________

BCBSD ID#: ____

Name of Primary Policyholder: ____

Street Address/Apt. #:____

City: ____ State: __________ Zip: ________________

Home Phone: _________________________________ Work Phone: ____________________________________

BCBSD ID #:__________________________________ DOB (mm/dd/yyyy): _______________________________

Employer or Group Health Plan Name if applicable: ____

■ **SECTION B. Appeal Information.* This appeal concerns the following claim:**

Claim Number:________________________________ Date of Service: _________________________________

Provider of Service (Doctor, hospital, etc): ____

____

** Please note that a member may appeal a claim only if he/she bears potential responsibility (in whole or in part) for payment of the claim.*

■ **SECTION C. Personal Representative Information.** ***I hereby designate*** the person identified in this section to be my personal representative for all matters concerning the BCBSD appeal identified in Section B, and ***I request*** that Blue Cross Blue Shield of Delaware (BCBSD) treat the named individual as it would otherwise treat me with regard to my protected health information concerning this appeal. ***I understand*** that this form is voluntary. ***I understand*** that federal privacy laws will no longer protect the released information when the person designated as my personal representative receives the information**.**

Name of Personal Representative ____

Last name: ___________________________________ First name:______________________________________

Street Address/Apt. #:____

City: ____ State: __________ Zip: ________________

Phone (home):________________________________ Phone (work): ____________________________________

Relationship to Member: ____

■ **SECTION D. Expiration and Revocation.** I understand that this designation is solely for the purpose of the BCBSD appeal identified in Section B and that it will expire at the time the final appeal decision is rendered. I also understand that I may revoke this designation of a personal representative at any time by giving written notice to BCBSD, but that the revocation will not affect any action that BCBSD may have taken before receipt of the Revocation. For my convenience, a revocation form is available at **bcbsde.com** or from BCBSD Customer Service.

Signature of Appellant (Member):____ Date:__________________

If a Legal Guardian or Attorney of Record signed this form on behalf of the Appellant (Member), please provide the following:

Name: ____ Relationship to Individual:__________________________

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