AUTHORIZED REPRESENTATIVE FORM FOR GRIEVANCE/APPEAL

Claim #:

SECTION A: ENROLLEE INFORMATION			
By signing this form in Section (G) below, I understand and agree that Community Care Alliance of Illinois (CCAI) may release my personal health information as defined in Section (C) below to my Authorized Representative name in Section (E) below, and that such authorized representative is authorized to file a Grievance/Appeal on my behalf, thereby exhausting my right to file such a Grievance/Appeal. This entire form must be filled out.			
Last Name	First Name		MI
Address	City	State	ZIP Code
Email	Home Phone #	Cell Phone #	
Enrollee ID (Located on your benefits card)		Birth Date	
Please Note: This authorization does not provide your Authorized Representative with any authority, either implied or direct, over any treatment or direct care decisions. If you would like to designate someone as your personal representative to act on your behalf in making decisions regrding your health care, please submit to CCAI a health care power of attorney or other valid instrument permitting such person to make decisions related to your health care.			

PART B: REQUEST TYPE (Choose only one request per form)

◯ **New Request -** This form is a request to assign a new Authorized Representative.

◯ **Update an Existing Request -** This form is to modify (i.e. change the limitations on) a previosuly approved authorized representative.

◯ **Revoke an Existing Request -** This form is to request termination of a previously approved authorized representative. Enter an effective date for the termination: _ _/_ _/_ _ _ _.

PART C: TYPE OF INFORMATION (What is being Appealed or Grieved)

Describe the specific health information you are authorized to be used or disclosed:

PART D: AUTHORIZED USE AND DISCLOSURE

Intended Use or Disclosure:

I understand that the general policy of CCAI is not to disclose my personal health informatin to other parties, except those directly involved in my care, without my written authorization or as permitted or required by law. For this reason, I authorize you to discuss and disclose my personal health information to the person(s) named below for the purpose of assisting with, or filing a Grievance/Appeal on my behalf. I also understand that if my Authorized Representative is not a health care provider or another entity subject to federal or applicable state privacy laws, my personal health information may no longer be protected by those privacy laws and my Authorized Representative may further disclose my personal health information without my authorization. I acknowledge that my authorization is voluntary.

PART E: INFORMATION on AUTHORIZED REPRESENTATIVE(S)

Name of Person or Organization	Relationship to Enrollee	Phone #
Name of Person or Organization	Relationship to Enrollee	Phone #

I understand that I have the right to limit the information that you release under this authorization. For example, I may limit my Authorized Representative's access to information about a particular health care provider or a particular diagnosis/disease. Any such limitations must be described below in writing. I understand that by leaving this section blank, I am creating no limitations on disclosure. I am entitled to keep of copy of this form for my records.

PART F: EXPIRATION AND REVOCATION

This authorization to release information to my Authorized Representative will automatically expire upon completion of the Grievance/Appeal filed on my behalf.

I understand that I can revoke this authorization at any time. I understand that, if I do not wish the person named in Section E to remain my Authorized Representative, I must revoke this authorization by giving written notice of my decision to CCAI Grievance/Appeals at the address listed below. I understand that my revocation of this authorization will not affect any action that CCAI has taken, or any information that CCAI may have already released, based upon this authorization before CCAI actually received my request to revoke it.

CCAI Grievance & Appeals Department
322 S. Green Street, Suite 400
Chicago, Illinois 60607
Fax: 312-491-9856

PART G: SIGNATURE

I have read this Authorized Representative Form. I understand that, by signing this form, I am confirming my authorization that CCAI may use and/or disclose my personal health information to the person(s) named in Section E for the purpose described above.

Signature of You or Your Personal Representative	
Please Print Name:	Date:
If signed by your personal representative, describe representative's authority to act on behalf of the customer:	

PLEASE RETURN THE SIGNED AUTHORIZATION FORM TO THE ADDRESS LISTED IN SECTION F.