MERITAIN APPEALS AUTHORIZATION FOR RELEASE OF INFORMATION

(NAME OF GROUP HEALTH PLAN)
Appointment of Authorized Representative for Meritain Appeal

I, _____ hereby appoint _____
(Name of claimant) (Name of Authorized Representative)
to act on my behalf in connection with the appeal for claim(s) for **date(s) of service** _____ for coverage or benefits, including receipt of any approvals or authorizations that are required before medical services are provided under the plan named above ("Plan"). I authorize my representative to file appeals on my behalf in connection with the appeal for claim(s) for **date(s) of service** _____ for coverage or benefits. I authorize my representative to receive all information that is provided to me and to act for me (or my dependent, if name above as the patient), in providing any information to the Plan that relates to the appeal for claim(s) for **date(s) of service** _____for coverage or benefits under the Plan.

IMPORTANT: All information and notifications from the Plan related to the appeal will be directed to the authorized representative appointed through this form and not to you, unless you direct otherwise below by checking below:

☐ Distribute to my authorized representative and me: All information and notifications should be distributed to my authorized representative and me.

_____ _____
Claimant's signature Date

Please return to:
Meritain Health Appeals Department
PO Box 41980
Plymouth, MN 55441