APPOINTMENT OF REPRESENTATIVE

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier (provider or supplier as party)

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint the individual named in Section 2 to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance or request wholly in my stead. I understand that personal medical information related to my request may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)	Fax Number (optional)	

Section 2: Acceptance of Appointment

To be completed by the representative:

I, , hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____
(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)	Fax Number (optional)	

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to, waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of HHS.

Signature	Date

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date

INSTRUCTIONS AND REGULATION REQUIREMENTS

Instructions

Name of Party (required): This is the name of the person or entity which has standing to file a claim or appeal (the name of the person who has Medicare, or the name of the provider or supplier).

Medicare Number or National Provider Identifier (required): This must be completed when the person or entity appointing a representative has a Medicare number or National Provider Identifier. If not applicable, fill in, "not applicable".

All fields in Sections 1 and 2 are required unless noted as optional within the field. See the regulation at 42 CFR 405.910.

Charging of Fees for Representing Beneficiaries before the Secretary of HHS

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of HHS (i.e., an Administrative Law Judge (ALJ) hearing or attorney adjudicator review by the Office of Medicare Hearings and Appeals (OMHA), Medicare Appeals Council review, or a proceeding before OMHA or the Medicare Appeals Council as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR 405.910(f).

The form, OMHA-118, "Petition to Obtain Approval of a Fee for Representing a Beneficiary" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing, OMHA review, or request for Medicare Appeals Council review. Approval of a representative's fee is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. The form, OMHA-118, may be found at: https://www.hhs.gov/sites/default/files/OMHA-118.pdf

Approval of Fee

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before HHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, OMHA or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

Conflict of Interest

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before HHS.

Where to Send This Form

Send this form to the same location where you are sending (or have already sent) your: appeal if you are filing an appeal, grievance or complaint if you are filing a grievance or complaint, or an initial determination or decision if you are requesting an initial determination or decision. If additional help is needed, contact 1-800-MEDICARE (1-800-633-4227, TTY users call 1-877-486-2048), or your Medicare plan.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit https://www.medicare.gov/about-us/accessibility-nondiscrimination-notice, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Member Authorization Form

I_____ appoint _____ as my authorized representative, to act on my behalf for the Inland Empire Health Plan (IEHP) services described below.

MEMBER INFORMATION: ***REQUIRED***

_____

Member Name | Member ID or SSN | Member DOB

AUTHORIZED REPRESENTATIVE INFORMATION: ***REQUIRED***

_____

Authorized Representative Name | Relationship To Member

_____

Authorized Representative Address | Authorized Representative Daytime Phone Number

AUTHORIZED SERVICES *(select any or all of the following):* ***REQUIRED***

This appointment allows my Authorized Representative to act on my behalf for the following IEHP member services:

- ❑Request my Protected Health Information
- ❑Change my Primary Care Physician (PCP)
- ❑Change my assigned IPA or Medical Group
- ❑File a Grievance or Appeal (for Medi-Cal only)
- ❑Change my Member demographic information (address, phone number, etc.)
- ❑Complete Health Risk Assessments or other Assessments to help my plan for care
- ❑Other: _____

PURPOSE & MEMBER RIGHTS: ***REQUIRED***

By filling out this appointment, I agree to have my authorized representative act on my behalf for the IEHP member services selected above.

IEHP and my authorized representative may only share the minimum necessary Protected Health Information (PHI) and other private facts to carry out IEHP services.

I understand that I do not have to sign this Appointment and it is completely voluntary. My refusal will not affect my ability to obtain treatment, payment or eligibility for benefits. I understand that I have a right to receive a copy. I further understand that if the information provided by this Authorization is disclosed (given) to another person or agency, it may no longer be protected by federal confidentiality law (HIPAA). However, California law does not allow the person receiving the health information by this Authorization to disclose it, unless a new Authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

I am aware that I may stop (revoke) this appointment at any time by sending a written request to IEHP at:
Inland Empire Health Plan | Attn: Member Services
P.O. Box 1800 | Rancho Cucamonga, CA 91729
Fax: 909-890-5877 | Email: MemberServices@iehp.org

This Appointment is effective immediately and will remain in effect for one year from the date of signature, or as indicated here: _____ (ending date).

IEHP
Inland Empire Health Plan

Member Authorization Form

AUTHORIZED REPRESENTATIVE ACCEPTANCE: ***REQUIRED***

I have read this form and understand that:

- the IEHP Member may revoke this appointment at any time and appoint another individual(s) to act as their authorized representative;
- I have no other power to act on the Member's behalf, except for the IEHP services as stated above;
- I may not transfer or reassign my appointment.

I certify that:

- I have never been disqualified, suspended, or prohibited from practice before the Social Security Administration or the Department of Health and Human Services.
- I am not a current or former employee of the United States, disqualified from acting as the Member's authorized representative

By signing below I hereby accept this appointment:

_____

Authorized Representative Signature Date

MEMBER SIGNATURE: ***REQUIRED***

By signing below I hereby authorize this appointment:

_____

Member Signature Date

PLEASE COMPLETE ALL SECTIONS, SIGN, AND RETURN THIS FORM TO:

Inland Empire Health Plan | Attn: Member Services
P.O. Box 1800 | Rancho Cucamonga, CA 91729
Fax: 909-890-5877
Email: MemberServices@iehp.org

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