MEMBER AUTHORIZATION FORM

A Public Entity
Inland Empire Health Plan

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.)
- ☐ Other: _____

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

By filling out this appointment, I agree to have my authorized representative to 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).

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IEHP
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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