Instructions for Completion –
**Commercial Appointment of Authorized Representative form**

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| 1. Member/Patient Information | **Demographic Information**: Fill in your First name, Last name, address information, date of birth and your Member/Patient ID. This information is required for identification and authentication purposes.<br>**Reference or Claim Number**: This is the claim number or other specific appeal or grievance details, that you would like your appointed representative to represent you and to speak to on your behalf, for an appeal or a grievance<br>**Facility/Provider Name and Description of service and/or date of denial of service or payment:** These are the Provider/Facility names and respective services and/or dates of service your authorized representative is pursuing on your behalf. |
| 2. Person I am authorizing to pursue my appeal or grievance | Write the first and last name, organizational affiliation/facility (if applicable) and address of the individual(s) that you authorize Optum/United Behavioral Health and its subsidiaries to represent you for an appeal or grievance and to disclose information regarding your care. **If not completed in its entirety, the form will be considered incomplete.** |
| 3. Member/Patient Signature | Adult Member must sign and date form. If member is a minor, the guardian must sign and identify their role to minor (Mother, father, etc.) under **Relationship to Member if a Minor**. Provide supporting legal documentation of role of authority if needed. The AOR expires 1 year from signature date. **If not completed in its entirety, the form will be considered incomplete.** |
| 4. Representative Signature | Person named in step 2 should sign and date form. **If not completed in its entirety, the form may be considered incomplete.** |

# Authorized Representative Form-Commercial Appeals & Grievances

A member (or "patient") may use this form to designate an authorized representative to act on his or her behalf regarding a grievance, or an appeal of a denial of service or payment.

Your legal representative may submit the appropriate legal documentation in place of this form. (For example: power of attorney, guardianship papers, foster parent certification or court order). You may be asked to provide additional supporting documentation to accompany this form.

1. **Member/Patient Information:** (Please provide the following information)

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| **First Name:** | **Last Name:** | |
| **Address:** | **City:** | **State:** |
| **Daytime Phone** (include area code): | **Member/Patient ID:** | |
| **Date of Birth** (mm/dd/yyyy): | **Reference or claim number (if known):** | |
| **Name of Facility/Provider: (including description e.g.: All appeals/**grievances**, Date of denial, Service, Payment or Type of care.):** | | |

2. **Person I am authorizing to pursue my appeal/**grievance**: (**Please provide the following information for your authorized representative)

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|---|---|---|
| **First Name:** | **Last Name:** | |
| **Organization/Facility (if applicable):** | | |
| **Address:** | **City:** | **State:** |
| **Daytime Phone:** (include area code): | | |

3. **Member/Patient**: By signing below I authorize the person named above to act on my behalf and receive information from United Behavioral Health and its subsidiaries in connection with my appeal/grievance. This information may include the following:

   All medical and financial information contained in my insurance file, including but not limited to treatment for venereal disease, alcoholism and drug abuse, abortion, mental disorder and HIV status relating to my examination, treatment and hospital confinement in connection with the grievance or determination which is being appealed.

I understand this information is confidential and will only be released as specified in this authorization. This authorization is only valid for 1 year from the date of the signature of Member/Patient or Legal Guardian below.

| Signature of Member/Patient or Legal Guardian / Parent if a minor. | Name of Member/Patient or Legal Guardian / Parent if a minor. (Please Print) | Relationship to Member if a minor | Date |
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4. **Representative:** By signing below you are certifying you will represent the member to the best of your abilities and do not have a conflict of interest posed by any relationships you may have with the insurance company or providers whom the member is seeking care.

| Signature of Authorized Representative | Name of Authorized Representative (Please Print) | Date |
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5. Please include a copy (keep the original) of the adverse determination notice you received.
6. Submit this completed form to AOR Processing via:

Fax to: 1-866-322-0051

Mail to: AOR Processing
11000 Optum Circle
Mail Route MN103-0600
Eden Prairie, MN 55344