California Pre-Service Clinical Appeal Authorized Representative Form

Use this form to appoint an individual or your practitioner as your authorized representative for pre-service clinical appeals. The form and the related authorization only extend to appeals under a California health care service benefit plan for which ASH processed the clinical decision being appealed. Your authorized representative may act for you on all duties related to such pre-service clinical appeals. You may cancel this appointment or change your authorized representative at any time. Failure to fully complete all sections of the form may result in the form being returned to you. Responses should be printed in the spaces provided using blue or black ink.

Part A: Member

Member Full Name	Member Date of Birth	Member ID Number
Member Mailing Address	**Member Health Plan**	

Part B: Authorized Representative

Full Name of Authorized Representative	Phone Number	Provider Tax ID Number
Mailing Address		
Email Address		

Release of My Personal Information and Protected Health Information: By signing this form below, I consent to ASH releasing my personal information, including my protected health information, to my named Authorized Representative for their advocacy on my behalf regarding any appeals of pre-service denials processed by ASH in relation to my health plan benefits. This consent is valid only for the period that this authorization remains valid.

Part C: Authorized Representative Duties

File a pre-service clinical appeal on behalf of Member. Only Members or their authorized representative may file a pre-service clinical appeal.

Part D: Read and sign

I. For Member:

By signing below, I appoint the individual or practitioner named in Part B as my authorized representative. I agree that:

- The authorized representative may submit pre-service clinical appeals on my behalf.
- This authorization is good for a period of one (1) year from the date I sign it. The authorization will expire after that time period.
- My rights and responsibilities do **not** change because I have an authorized representative.
- I must make sure that I respond to all requests for information
- The authorized representative may cancel this appointment at any time.
- You may contact the ASH Customer Service Department to change or cancel this appointment at any time. The ASH Customer Service department can be reached at 1-800-678-9133

II. For Authorized Representative:

- You may cancel the assignment of authorized representative at any time by contacting the ASH Customer Service department at 1-800-678-9133
- As an authorized representative, you agree to:
  - Submit pre-service clinical appeals on behalf of the member.
  - Obey all state and federal laws governing authorized representatives.

Please email, fax, or mail the completed form to the American Specialty Health Appeals and Grievances Department.

Email
Appeals@ashn.com

Fax Number
1-877-404-2746

Mailing:

PO Box 509001 San Diego, CA. 92150

By signing below, I agree to the authorizations and consents provided as stated above:

Member Printed Name	
Member Signature	**Date**