Med-Pay

A Point•C Partner

Designation of Authorized Representative Form

An Authorized Representative is a person you authorize to act on your behalf, in pursuing a claim or an appeal of a denied claim. This authorization may be either (1) granted for a particular date of service, or (2) granted for any present or future claim for health care benefits you may have.

I, _____, hereby appoint_____
(Print Name) (Name of person OR entity you are authorizing to act on your behalf)

as an Authorized Representative, to act on my behalf in the filing of claims and/or of appeals in connection with the following health care claims (check one):

___ _____; or
(Description of claim(s) issue, date(s) of service, provider(s) of service, and any other pertinent information available)

___ any present or future claim for health care benefits.

I understand that as a result of this authorization, Med-Pay, LLC may disclose and release information concerning benefit eligibility, claim status, claim approval, denial reasons, medical treatment and diagnosis in connection with the above referenced health care claims to the individual named above. Further, I understand that the information released may include Protected Health Information (PHI). PHI is individually identifiable health information that relates to my past, present or future physical or mental health or condition; the provision of health care to me; or the past, present or future payment for the provision of health care to me.

This designation is subject to revocation at any time by the designator except to the extent that Med-Pay, LLC has taken action in reliance on this designation before knowing of the revocation. If not revoked sooner, this designation will continue for a period of one year from the date it is signed.

_____ _____
Print name of patient Print name of legal representative, if applicable

_____ _____
Signature of patient Signature of legal representative, if applicable

_____ _____
Date Date

_____
Patient's date of birth

A COPY OF THIS AUTHORIZATION SHALL SERVE THE SAME PURPOSE AS THE ORIGINAL

Send completed form to Med-Pay, LLC, PO Box 10909, Springfield, MO 65808 or fax to 417-890-0741. For question, please call 417-886-6886 or toll free at 1-800-777-9087.