BlueAdvantage Administrators of Arkansas

An Independent Licensee of the Blue Cross and Blue Shield Association

Designation of Authorized Appeal Representative

Plan Administrator: _____

Plan Participant Name: _____

Participant ID Number: _____

The Plan is a self-funded ERISA plan. The Plan will accept appeals only from you, the Plan participant, unless you properly designate someone else to appeal on your behalf. In order to properly designate someone else to pursue an appeal on your behalf, the Plan requires that you and the person you wish to designate as your Authorized Appeal Representative must each sign this form, indicating that both you and the person you designate as your Authorized Appeal Representative agree to the terms and conditions stated in this form. If you or your designated Authorized Appeal Representative do not agree to any statements or terms set forth in this form, do not sign this form.

Once you and your designated Authorized Appeal Representative have each signed this form and returned it to the Plan Administrator at the address listed below, please understand that you have authorized the following to occur:

1. By signing this form, you give permission for the Authorized Appeal Representative to exercise your appeal rights under the Plan.
2. Signature of this form also gives the Authorized Appeal Representative access to all of your medical information and claims for health care benefits under the Plan, to the extent that any of them are relevant to your appeal.
3. Signature of this form authorizes the Plan and any of its representatives, including the Claim Administrator for the Plan, to communicate directly with the Authorized Appeal Representative with regard to your appeal, as well as all related information such as claims, medical records, explanation of benefits, telephone calls, correspondence, your address, telephone numbers, social security number and Plan identification numbers, premium payments or other Plan eligibility data.
4. Upon proper submission of this signed from, the Plan will communicate directly to your Authorized Appeal Representative – rather than to you – the Plan's decision regarding your appeal, as well as other information related to the appeal.

If you wish to designate an appeal representative, please complete parts A through D of this form and forward it to the Plan Administrator at the address shown at the bottom of this form.

D. SIGNATURE OF AUTHORIZED APPEAL REPRESENTATIVE

The undersigned hereby accepts designation by the above-named Plan Participant to act as Authorized Appeal Representative. The undersigned understands and agrees that any claim for benefits allegedly due under the Plan, whether asserted on behalf of the Plan Participant or asserted by the undersigned on its own behalf as assignee or agent of the Plan Participant, is subject to and governed by the terms and conditions policies and procedures of the Plan. The undersigned hereby agrees to abide by all terms and conditions of the Plan, including such allowances and payment limitations as the Plan, by its terms, may establish. In accepting this designation, the undersigned hereby represents that it will keep the Plan Participant fully informed on a timely basis of the status of any appeal and of all related communications exchanged with the Plan or its third party administrator. The undersigned agrees to fully discharge the undersigned's obligations to the Plan Participant in acting as the Plan Participant's agent with respect to any appeal. Should the Plan Participant at any time indicate to the undersigned a desire to revoke this designation, the undersigned agrees to immediately cease acting on behalf of the Plan Participant, and to provide prompt, written notice of the same to the Plan and its third party administrator.

_____

Signature of Authorized Appeal Representative

_____

Print Name

_____

Date Signed

E. ADDRESS OF PLAN ADMINISTRATOR:

Please return this signed form to the Plan Administrator at:

_____

_____

_____

_____

A. IDENTIFICATION OF CLAIMS YOU WISH TO APPEAL

Please list the claims you authorize the Authorized Appeal Representative to appeal for you:

Name of Health Care Provider	Date(s) of Service	Amount You claim is owed by Plan
_____	_____	_____
Name of Health Care Provider	Date(s) of Service	Amount You claim is owed by Plan
_____	_____	_____

NOTE: *If all claims will not fit in the spaces provided above, you may submit an additional page, showing the requested details; however, the additional page MUST BE SIGNED AND DATED BY YOU or it will not constitute a valid authorization for the Authorized Appeal Representative to represent you with respect to appeal of any such identified claims.*

B. IDENTIFICATION OF YOUR AUTHORIZED APPEAL REPRESENTATIVE

In the space below, enter the full name of your Authorized Appeal Representative, along with their address and telephone number:

_____
Name of Authorized Appeal Representative (Please Print)

_____
Address of Authorized Appeal Representative

_____
Telephone Number of Authorized Appeal Representative

C. YOUR SIGNATURE

_____
(Signature of the Plan Participant)

_____
(Print Name)

_____
(Date Signed)

NON-DISCRIMINATION AND LANGUAGE ASSISTANCE NOTICE

NOTICE: Our Company complies with applicable federal and state civil rights laws and does not discriminate, exclude, or treat people differently on the basis of race, color, national origin, age, disability, or sex.

We provide free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in various formats (large print, audio, accessible electronic formats, other formats), and language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. **If you need these services, contact our Civil Rights Coordinator.**

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
601 Gaines Street, Little Rock, AR 72201
Phone: 1-844-662-2276; TDD: 1-844-662-2275

You can file a grievance in person, by mail, or by email. If you need help filing a grievance our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201
Phone: 1-800-368-1019; TDD: 1-800-537-7697

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-844-662-2276.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-662-2276.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-662-2276.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-662-2276.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-662-2276 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-662-2276.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-662-2276.

ملاحظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. إتصل بالرقم 1-844-662-2276.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-844-662-2276.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-662-2276.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-662-2276.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-844-662-2276.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-844-662-2276.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-662-2276 まで、お電話にてご連絡ください。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-662-2276.

توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات و کمک‌های زبانی رایگان برای شما موجود است. برای کسب اطلاعات بیشتر، با شماره 1-844-662-2276 تماس بگیرید.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-844-662-2276.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-662-2276 पर कॉल करें।

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-844-662-2276.

انتباہ: اگر آپ اردو بولتے ہیں تو، آپ کے لئے زبان کی مدد کی خدمات بلا معاوضہ دستیاب ہیں۔ 1-844-662-2276 پر کال کریں۔

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-844-662-2276.

LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk 1-844-662-2276.