CONSENT TO NAME AN AUTHORIZED REPRESENTATIVE TO PURSUE AN APPEAL OF AN ADVERSE BENEFITS DETERMINATION INVOLVING MEDICAL JUDGEMENT

&

AUTHORIZATION TO RELEASE INFORMATION RELATING TO THE APPEAL

I[1], ____________________, by signing below, agree to representation by the following authorized representative,____________________, to act on my behalf in an appeal of an adverse benefits determination involving medical judgment as allowed by the Patient Protection and Affordable Care Act (PPACA) Public Law 111-148, and Section 2719 of the Public Health Services Act (PHS Act) which PPACA has incorporated into the Employment Retirement Income Security Act (ERISA) and the Internal Revenue Code (the Code), making those provisions applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. I also agree to the release of my personal health information to my appointed authorized representative named herein, to Horizon BCBSNJ and its independently contracted Independent Review Organization (IRO) that will review my appeal. My consent to this appointment of this authorized representative and my authorization of release of my personal health information expires in 24 months, but I may revoke both sooner.

Signature: ____________________ Ins. ID#:____________ Date: ____________

Relationship to Patient: [ ] I am the patient [ ] I am a Personal Representative

[1] If the patient is a minor, or unable to read and complete this form f due to mental or physical incapacity, a personal representative of the patient may complete this form.