Designation of Authorized Representative Form

Authorization

I, _____, do hereby designate all employees of Orthopaedic Associates of Riverside and Orthopaedic Associates of Riverside Physical and Occupational Therapy, to the full extent permissible under the Employee Retirement Income Security Act of 1974 (ERISA) and as provided in 29 CFR 2560-503-1(b)4, to otherwise act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expenses incurred as a result of the services I receive(d) from the above named. These rights include:

1. The right to act on my behalf with respect to initial determinations of claims
2. The right to pursue appeals of benefit determinations under my plan
3. The right to obtain any records related to my Protected Health Information, including health plan benefit information, claims, service determination, and my summary plan description
4. The right to claim on my behalf such medical or other health care service benefits, insurance or health care benefit plan reimbursement and to pursue any other applicable remedies.

I understand that as a result of this authorization, _____ may disclose and release information concerning benefit eligibility, claim status, or claim approval/denial reasons in connection with the above referenced health care claims to the above named.

Expiration: This authorization will expire one year from the date it is signed.

Right to Revoke: I understand I may revoke this authorization at any time by giving written notice to my insurance company and to the above named. I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.

Signature

I understand this authorization is voluntary and that the health plan cannot condition my eligibility for benefits, treatment, enrollment, or payment of claims on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

_____ _____

(Patient/Guardian's Signature) (Date)

_____

(Patient/Guardian's Printed Name)

Staff Initials_____