WPS HEALTH INSURANCE
1717 W. Broadway • P.O. Box 8190 • Madison, WI • 53708-8190

THE EPIC LIFE INSURANCE COMPANY
A WPS Company

AUTHORIZED REPRESENTATIVE FORM FOR GRIEVANCE/APPEAL

Claim #: **and/or Date of Service:**

Section A: Member Information

By signing this form in Section E below, I understand and agree that Wisconsin Physicians Service Insurance Corporation ("WPS") may release my personal health information as defined in Section B below to my Authorized Representative named in Section C below, and that such Authorized Representative is authorized **to file a Grievance/Appeal** *on my behalf*, thereby exhausting my right to file such a Grievance/Appeal. **This complete form must be filled out.**

Customer Name: _____

Address: _____

Telephone Number: _____ WPS Customer Number: _____

Please Note: This authorization does not provide your Authorized Representative with any authority, either implied or direct, over any treatment or direct care decisions. If you wish to designate an individual as your personal representative to act on your behalf in making decisions regarding your health care, please submit to WPS a health care power of attorney or other valid instrument permitting such individual to make decisions related to your health care. Also, WPS will not condition benefits payments, enrollment, or eligibility for benefits upon the execution of this form.

Section B: Type of Information (What is being Appealed or Grieved)

Describe the specific health information you are authorizing to be used or disclosed:

_____

_____

Section C: Authorized Use and / or Disclosure

Intended Use or Disclosure:
I understand that the general policy of WPS is to not disclose my personal health information to other parties, except those directly involved in my care, without my written authorization or as permitted or required by law. For this reason, I authorize you to discuss and disclose my personal health information to the person named below for the purpose of assisting with, or filing, a Grievance/Appeal on my behalf. I also understand that if my Authorized Representative is not a health care provider or another entity subject to federal or applicable state privacy laws, my personal health information may no longer be protected by those privacy laws and my Authorized Representative may further disclose my personal health information without my authorization. I acknowledge that my authorization is voluntary.

Authorized Representative Information (Parent, Spouse, Doctor, Facility, or other Authorized Representative):

Name: Phone Number:

Address:

Relationship to Customer:

Limitations on Disclosure:
I understand that I have the right to limit the information that you release under this authorization. For example, I may limit my Authorized Representative's access to information about a particular health care provider or a particular diagnosis/disease. Any such limitations must be described below in writing. I understand that by leaving this section blank, I am creating no limitations on disclosure. I am entitled to keep of copy of this form for my records.

Section D: Expiration and Revocation

This authorization to release information to my Authorized Representative will automatically expire upon completion of the Grievance/Appeal filed on my behalf.

I understand that I have the right to revoke this authorization at any time. I understand that, if I do not wish the person named in Section C to remain my Authorized Representative, I must revoke this authorization by giving **written** notice of my decision to WPS Grievance/Appeals at the address listed below. I understand that my revocation of this authorization will not affect any action that WPS has taken, or any information that WPS may have already released, based upon this authorization before WPS actually received my request to revoke it.

WPS Grievance/Appeals
P.O. Box 7062
Madison, WI 53707

Section E: Signature

I have read this Authorized Representative Form. I understand that, by signing this form, I am confirming my authorization that WPS may use and/or disclose my personal health information to the person(s) named in Section C for the purpose described above.

Signature of You or Your Personal Representative:	
Please print name:	Date:
IF SIGNED BY YOUR PERSONAL REPRESENTATIVE, DESCRIBE REPRESENTATIVE'S AUTHORITY TO ACT ON BEHALF OF THE CUSTOMER: _____	

PLEASE RETURN THE SIGNED AUTHORIZATION FORM TO THE ADDRESS LISTED IN SECTION D.