1)

APPOINTMENT OF REPRESENTATIVE AND AUTHORIZATION TO DISCLOSE INFORMATION

I appoint _____

Name and address of representative

To act as my representative in connection with my appeal under KRS 304.17A – 617 (2) (c) (2). I also authorize Kentucky Health Cooperative Inc. (KYHC) to release to said representative, information related to medical treatment, and if necessary, photocopies of any medical records which may be required for adjudication of my claim for Kentucky Health Cooperative Inc. (KYHC) benefits.

I understand the representative shall have the same authority as the part to the appeal and notice given to the representative shall constitute notice to the part.

This consent will expire upon the issuance of the final agency decision regarding my appeal. However, I reserve the right to withdraw this authorization at any time.

_____ _____

Date *Signature of Patient/Guardian/Legal Representative*

_____

Please Print Name

_____

Member ID Number

_____

Authorization Number

Instructions for completing this form:

1. You must insert the name of the person {your spouse, son/daughter, or legal guardian, your physician or facility, hospital, ambulatory surgery center, radiology center} you are appointing as your representative to act in your behalf of the appeal. This person's or facility's name goes on the top line along with their address.
2. Please sign, date and have the appointed person or facility return this form along with the written request for an appeal.

Mail or Fax to:

Kentucky Health Cooperative

ATTN: Utilization Management Department

9700 Ormsby Station Road, Suite 100

Louisville, KY 40223

(502) 272-4587 (fax)

Appeals@mykyhc.org (e-mail)