WPS HEALTH SOLUTIONS WPS HEALTH INSURANCE Arise HEALTH PLAN EPIC SPECIALTY BENEFITS

AUTHORIZED REPRESENTATIVE FORM FOR GRIEVANCE/APPEAL

Claim#:	**Date of Service:**

PART A: MEMBER INFORMATION

By signing this form in Part F below, I understand and agree that Wisconsin Physicians Service Insurance Corporation (WPS Health Solutions or WPS Health Insurance), and/or its wholly owned subsidiaries, The EPIC Life Insurance Company (EPIC Specialty Benefits), and WPS Health Plan, Inc. (Arise Health Plan) (hereinafter "WPS Health Solutions") may release my personal health information as defined in Part B below to my Authorized Representative named in Part 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 in its entirety.**

Member Last Name	Member First Name	M. I.	Member Date of Birth

Member Street Address	City	State	Zip Code

Phone # (including area code)	Cell Phone# (including area code)	Subscriber Number (ID Card)

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 care representative to act on your behalf in making decisions regarding health care, please submit to WPS Health Solutions a valid health care power of attorney, including any supporting documentation that may be needed to trigger application of the power of attorney (e.g., state of incapacity) or other valid instrument permitting such individual to make decisions related to your health care. **WPS Health Solutions will not condition benefits payments, enrollment or eligibility for benefits upon the execution of this form.**

PART B: TYPE OF INFORMATION (WHAT IS BEING APPEALED OR GRIEVED)

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

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PART C: AUTHORIZED USE AND/OR DISCLOSURE

Intended Use or Disclosure: I understand that the general policy of WPS Health Solutions is not to 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 other entity subject to federal or applicable state privacy laws, my personal health information without my authorization. I acknowledge that my authorization is voluntary.

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

Name:	Phone #:	Cell #:

Relationship to Customer:	Mailing Address:

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 in writing below. I understand that by leaving this section blank, I am creating no limitation on disclosure. I am entitled to keep a copy of this form for my records.

_____

IMPORTANT: All information and notifications from WPS Health Solutions will be directed ONLY to the Authorized Representative named in this Part C, unless you direct otherwise below:

☐ All information and notifications should be distributed to me AND to my Authorized Representative listed above.

****MAIL OR FAX COMPLETED FORM TO APPROPRIATE ADDRESS OR FAX NUMBER LISTED IN PART E****

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PART D: EXPIRATION & 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 Part C to remain my Authorized Representative, I must revoke this authorization by giving written notice of my decision to WPS Health Solutions Grievance/Appeals at the address listed below. I understand that my revocation of this authorization will not affect any action that WPS Health Solutions has taken, or any information that WPS Health Solutions may have already released, based upon this authorization before WPS Health Solutions actually received my request to revoke it.

PART E: MAILING ADDRESS/FAX

Please mail or fax your completed form to the appropriate address or fax number based on your type of plan.

WPS Health Solutions
Mail or Fax to:
WPS Grievance/Appeals
P.O. Box 7062
Madison, WI 53707-7062
Fax (608) 221-6168

Arise Health Plan
Mail or Fax to:
WPS Health Plan, Inc. Grievance/Appeals
P.O. Box 11625
Green Bay, WI 54307-1626
Fax (608) 920-490-6955

EPIC Specialty Benefits
Mail or Fax to:
The EPIC Life Insurance Company Claims Dept.
P.O. Box 8430
Madison, WI 53708-8430
Fax (608) 223-2179

PART F: MEMBER SIGNATURE OR AUTHORIZED REPRESENTATIVE/GUARDIAN

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

Member signature or Designated Legal Representative/Guardian signature **X**	**Date**

If signed by Authorized Representative: (1) Print your name, (2) State the legal authority for your status as Member's representative, and (3) attach supporting documentation:

****MAIL OR FAX COMPLETED FORM TO APPROPRIATE ADDRESS OR FAX NUMBER LISTED IN PART E****