Appointment of Representative Form Instructions

If you wish to name a family member, a friend, or a person whom you trust to act on your behalf to ask to file an appeal or a grievances with Partners Health Plan, both you and the individual you choose must fill out and sign this **Appointment of Representative Form (AOR)**. Please know that unless it is revoked, the appointment will be valid for one year from the signature date.

Section 1 | Appointment of Representative

- Give the full name of the person you are appointing as your representative. Sign and date this section and fill in your address, phone number, and email address.
- Please know that by appointing the person to act as your representative, you are granting this person legal authority and access to your health information related to this request.

Section 2 | Acceptance of Appointment

- The individual to whom you give permission to act on your behalf will need to fill out this section if they agree to this appointment. Give us your full name; your status (e.g., lawyer) or relationship to the member/participant. Be sure to sign, date, and fill out the rest of this section.

Section 3 | Waiver of Fee for Representation

- Your representative (other than your doctor or supplier) can charge you a fee for representing you; but if they wish to waive the fee, they will need to sign and date this section.
- Note that if your doctor or supplier is acting as your representative, he or she cannot charge a fee for representing you, and they MUST sign this section.

Section 4 | Waiver of Payment for Items or Services at Issue

- This section is needed only if your doctor or supplier is acting as your representative. By completing this section, your doctor or supplier, if sending the request on your behalf, agrees to waive the right to bill you for services that Medicare does not cover.

Return the completed and signed form to Partners Health Plan by mail or email:

Partners Health Plan
2500 Halsey Street
Bronx, NY 10461

operations@phpcares.org

For more information, visit www.phpcares.org or call (855) 747-5483/TTY 711. 7 days a week, 8:00 AM - 8:00 PM
The State of New York has created a Participant Ombudsman Program called the Independent Consumer Advocacy Network (ICAN) to provide participants free, confidential assistance on any services offered by Partners Health Plan. ICAN may be reached toll-free at 1-844-614-8800 (TTY users call 711, then follow the prompts to dial 844-6 14-8800) or online at icannys.org.
Partners Health Plan is a managed care plan that contracts with Medicare and the New York State Department of Health (Medicaid) to provide benefits to Participants through the Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) Demonstration.

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved OMB No.0938-0950

Appointment of Representative

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier (provider or supplier as party)

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint this individual, _____, to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the Act) and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance or request wholly in my stead. I understand that personal medical information related to my request may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 2: Acceptance of Appointment

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____

(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to, waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of HHS.

Signature	Date

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.) I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date

Charging of Fees for Representing Beneficiaries before the Secretary of HHS

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of HHS (i.e., an Administrative Law Judge (ALJ) hearing or attorney adjudicator review by the Office of Medicare Hearings and Appeals (OMHA), Medicare Appeals Council review, or a proceeding before OMHA or the Medicare Appeals Council as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR 405.910(f).

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing, OMHA review, or request for Medicare Appeals Council review. Approval of a representative's fee is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation

Approval of Fee

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before HHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, OMHA or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

Conflict of Interest

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before HHS.

Where to Send This Form

Send this form to the same location where you are sending (or have already sent) your: appeal if you are filing an appeal, grievance or complaint if you are filing a grievance or complaint, or an initial determination or decision if you are requesting an initial determination or decision. If additional help is needed, contact 1-800-MEDICARE (1-800-633-4227) or your Medicare plan. TTY users please call 1-877-486-2048.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you believe you've been discriminated against. Visit https://www.cms.gov/about-cms/agency-Information/aboutwebsite/cmsnondiscriminationnotice.html, or call 1-800-MEDICARE (1-800-633-4227) for more information.
