Appointment of Representative Form

Section 1: Appointment of Representative

To be completed by the party/applicant seeking representation (i.e., the Medicaid beneficiary):

Name of Party/Applicant:
Medicaid Number (beneficiary as party/applicant) or National Provider Identifier (provider or supplier as party/applicant):
Street Address:
Phone Number (with Area Code):
City, State, ZIP Code:
Email Address (optional):

I hereby appoint the individual identified in Section 2 below to act as my Authorized Representative and authorize him/her to represent me regarding my rights and responsibilities concerning my protected health information maintained by PSM and ASES. I authorize this individual to make any request; to present or to elicit evidence; toobtain appeals information; and to receive any notice in connection with my claim, appeal,or grievance on my behalf. I understand that personal medical information related to my request may be disclosed to the Authorized Representative indicated below.

Signature of Party/Applicant: _____ Date: _____

Section 2: Acceptance of Appointment

To be completed by the Authorized Representative:

Name of Authorized Representative:
Professional status or relationship to the Party/Applicant (e.g., provider, attorney, relative,etc.):
Street Address:
Phone Number (with Area Code):
City, State, ZIP Code:
Email Address (optional):

I hereby accept the above appointment. I certify that the above personal information is correct; that I have not been disqualified, suspended, or prohibited from practice before ASES or the U.S. Department of Health and Human Services; and that I am not, as a current or former employee of the Government of Puerto Rico or the U.S., disqualified from acting as the party's representative.

Signature of Authorized Representative: _____ Date: _____

Section 3: Waiver of Fee for Representation

This section must be completed if the Authorized 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 in question may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing this Party/Applicant beforePSM and ASES.

Signature of Authorized Representative: _____ Date: _____

PLAN DE SALUD MENONITA
1866-600-4753 (libre de cargos) 1-844-726-3345 TTY (audioimpedidos)
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1-800-981-2737
TTY 787-474-3389

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame 1-866-600-4753 (TTY: 1-844-726-3345).
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-866-600-4753 (TTY: 1-844-726-3345) al 1-866-600-4753 (TTY: 1-844-726-3345).
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電（TTY:1-866-600-4753; 1-844-726-3345.
PSM cumple con las leyes estatales y federales aplicables de derechos civiles y no discrimina por razón de raza, edad, color, origen de nacionalidad, discapacidad o sexo.

Este documento puede estar disponible en formatos alternativos como letra grande, audio u otros idiomas. Si necesita recibir estos servicios, llame al 1-866-600-4753 y 1-844-726-3345 TTY (audio impedidos).

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