CalOptima Health
A Public Agency
505 City Parkway West
Orange, CA 92868
☎ 714-246-8400
TTY: 711
caloptima.org

Appeal and Grievance Authorized Representative Designation Form

Section 1: Member Information

Member Name: _____ Date of Birth: _____

Member CIN: _____ Phone: _____

Section 2: Authorized Representative Information

Representative Name: _____

Agency (if applicable): _____

Relationship to Member: _____

Email: _____ Phone: _____

Address: _____

Section 3: What I Allow My Representative to Do

I give the person or agency listed above permission to act on my behalf with CalOptima Health during the appeal and/or grievance process:

☐ File an appeal

☐ File a grievance

☐ File an appeal and grievance

Please tell us which appeal or grievance you want your representative to help with.

- Date of service or decision: _____

- Description of provider, service or issue involved:

  _____

  ☐ Only the appeal or grievance above
  ☐ Any grievance or appeal I file while this authorization is in effect

Your representative may only act on your behalf in the appeal or grievance matter you choose above. Your representative may also communicate directly with CalOptima Health on your behalf. This includes receiving notices and letters, submitting documents and evidence, and reviewing or getting copies of case files and information related to the appeal or grievance.

Section 4: How Long This Permission Lasts (End Date)

This authorization for the named person or agency will end on: _____

_____

(Write a specific date or event. The date must be no later than one year after you sign and return this form.)

If you don't write an end date or describe when this authorization should stop, we can't accept this form. The end date must include the month, day and year.

You can write an event instead of a date. For example: "when the appeal or grievance is finished," "after the appeal or grievance is submitted," or "after I leave the hospital."

Section 5: Member Acknowledgment

I understand that:

- My authorized representative can access and talk about my protected health information (PHI) related to appeals and grievances.
- My health information may be shared again by my authorized representative and may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA privacy law).
- My treatment, payment or eligibility for benefits will not depend on whether I sign this authorization.
- I can cancel this authorization at any time by letting CalOptima Health know in writing.
- Canceling will not change anything already done using this authorization.

By signing this form, I authorize CalOptima Health to disclose PHI related to the grievance(s) and/or appeal(s) on this form to my authorized representative.

Section 6: Signature

Member signature or signature of member's legal representative:

Print: _____

Signature: _____ Date: _____

Relationship to Member: _____
(self, parent, health care agent, power of attorney, or executor of estate)

Supporting documents attached for legal representative:

☐ Yes ☐ No ☐ On file ☐ Not applicable

Please mail or fax this form to CalOptima Health:

Attn: Enrollment and Reconciliation
505 City Parkway West
Orange, CA 92868

Fax: 1-714-338-3104

This form **only** gives someone permission to represent you for an appeal and/or grievance handled by CalOptima Health. It does not give your representative permission to act for you on Medi-Cal eligibility or enrollment matters or for State Fair Hearings. You may need to complete a separate form for these matters.

If you need help, call CalOptima Health Customer Service toll-free at **1-888-587-8088** (TTY **711**), Monday–Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language.