50 Whitecap Drive
North Kingstown, RI 02852

First Name Last Name
Address
City State Zip

A four-page HIPAA release form is enclosed with this cover sheet.

The Health Insurance Portability and Accountability Act (HIPAA), is a 1996 Federal law that protects privacy by restricting access to an individuals' medical information.

A HIPAA release gives Amwins Group Benefits, LLC, (the 3rd party administrator of your health plan) indefinite permission to share information about your health insurance benefits, billing or claims with a trusted 3rd party person of your choosing. This person might be a spouse, family relation, friend or a trusted professional like a lawyer or accountant. Completing this form allow us to share information about your billing, plan benefits and medications with the designated individual.
The HIPAA release is not the same as a power of attorney. Your designated person will not be authorized to change anything about your account.

Each form is only good for one person, but you can submit multiple forms.

Add the name of your 3rd party representative as the "Authorized Party" on page 1. You should sign Section I on page 2. Your 3rd party representative should sign Sections II, III and IV.

Please be advised that the Appointment of Representative (AOR) is only valid for 1 year from the date of signature, which means a new form will need to be filled out every year.

If you have any questions, please contact the Customer Care Center at 1-855-693-3921, 7 days a week 24 hours a day, TTY/TDD users should call 711.

Return the completed paperwork to the following address:

Retiree RxCare
C/O Policy Administration
50 Whitecap Drive
North Kingstown, RI 02852

Sincerely,
Retiree RxCare
Policy Administration

HIPAA Privacy Rules

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

The following information is required to ensure compliance of the Health Insurance Portability & Accountability Act of 1996, Public Law 104-191, regarding the standards for privacy of individually identifiable health information. The written authorization of the insured, named under the insurance policy or insurance plan, is required when a third party representative of the insured, is authorized to communicate related Protected Health Information (PHI).

Insurance Co. Name **Member ID**	**Retiree RxCare**
Insured Name	
Insured's Address & Phone Number	
Group Name	
Insured Signature	_____ **Sign here authorizing the individual named below**
Authorized Party's Name/ Relationship to Insured	_____ _____ **Print Name** **Relationship**
Authorized Party's Address & Phone Number	_____ **Street Address** _____ **City, State, Zip Code** _____(_____)_____-_____ **Phone Number**
Authorized Party's ID #	_____ **Last four digits of your Social Security #**
Authorized Party's signature	_____ **Authorized Party sign here**

FOR INTERNAL USE ONLY – HIPAA PRIVACY OFFICE	
_____ **Date Received**	_____ **Insured Account #**

Form Approved
OMB no. 0938-0950

APPOINTMENT OF REPRESENTATIVE

NAME OF BENEFICIARY:	MEDICARE NUMBER:

SECTION I: APPOINTMENT OF REPRESENTATIVE
To be completed by the beneficiary:

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 appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

_____
SIGNATURE OF BENEFICIARY DATE

_____
STREET ADDRESS PHONE NUMBER (AREA CODE)

_____
CITY, STATE ZIP

SECTION II: 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; that I am not, as a current or former employee of the United States, disqualified from acting as the beneficiary'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 BENEFICIARY DATE

_____
STREET ADDRESS PHONE NUMBER (AREA CODE)

_____
CITY, STATE ZIP

SECTION III: WAIVER OF FEE FOR REPRESENTATION

Instructions: This form should be filled out if the representative waives a fee for such representation. (Note that providers or suppliers may not charge a fee for representation and thus, all providers or suppliers that furnished the items or services at issue **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of the Department of Health and Human Services.

SIGNATURE DATE

SECTION IV: WAIVER OF PAYMENT FOR ITEMS OR SERVICES AT ISSUE

Instructions: Providers or suppliers that furnished the items or services at issue 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, and 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 furnished items or services at issue involving 1879(a)(2) of the Act.

SIGNATURE DATE

CHARGING OF FEES FOR REPRESENTING BENEFICIARIES BEFORE THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Department of Health and Human Services (DHHS) at the Administrative Law Judge (ALJ) or Medicare Appeals Council (MAC) level is required by law to obtain approval of the fee in accordance with 42 CFR §405.910(f). A claim that has been remanded by a court to the Secretary for further administrative proceedings is considered to be before the Secretary after the remand by the court.

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 DHHS. Where a representative has rendered services in a claim before DHHS, the regulations require that the amount of the fee to be charged, if any, for services performed before the Secretary of DHHS be specified. If any fee is to be charged for such services, a petition for approval of that amount must be submitted.

An approval of a fee is not required where the appellant is a provider or supplier or where the fee is for services (1) rendered in an official capacity such as that of legal guardian, committee, or similar court-appointed office and the court has approved the fee in question; (2) in representing the beneficiary before the federal district court of above, or (3) in representing the beneficiary in appeals below the ALJ level. 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.

AUTHORIZATION OF FEE

The requirement for the approval of fees ensures that representative will receive fair value for the services performed before DHHS on behalf of a claimant while at the same time giving a measure of security to the beneficiaries. In approving a requested fee, the ALJ or MAC considers the nature and type of services performed, 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 DHHS.