

APPOINTMENT OF REPRESENTATIVE



As a member, you may appoint any individual (e.g., a friend, relative, lawyer) as your representative to assist you with understanding and following coverage determinations, exceptions, appeals or grievances.

Please note, a representative who is appointed by the court or who is acting in accordance with state law also may file a request on your behalf and must send us appropriate legal documentation demonstrating they are your legal representative. You will not need to complete an Appointment of Representative Form if this other documentation is provided.

If you wish to appoint an individual as your representative, please send us a completed Appointment of Representative form. The form must be signed, dated, and completed by both you and your representative. The Appointment of Representative form will be valid for a period of one year from the date it is completed.

How to Complete the Appointment of Representative Form

Fill in your name, if you are the member who is appointing the representative.

Fill in your Medicare Beneficiary Identifier (MBI) or plan ID number.

Section I—You, the member, complete Section I:

1. Fill in the name of the person you want to be your representative. You are granting this person access to private health information related to your Medicare plan.
2. Sign your name in the Signature of Party Seeking Representation box.
3. Enter the date of your signature.
4. Enter your address and phone number.

Section II—Your representative completes Section II:

1. Your representative fills in their full name.
2. Your representative fills in their professional status (such as attorney) or relationship to you (such as relative).
3. Your representative signs their name.
4. Your representative enters the date of the signature.
5. Your representative enters their address and phone number.

Section III—Your representative may need to fill in Section III. The representative may not be required to sign Section III:

- If your representative wishes to waive the fee, this is the place to sign and date that statement.
- If your provider or your supplier is your representative, they CANNOT charge a fee. In this case, they must sign and date Section III.
- Your representative may be someone you employ to represent you, and it may be appropriate for them to charge a fee (e.g., a lawyer). In this case, they will not sign Section III.

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Section IV—Your providers and/or suppliers may need to fill in Section IV. The representative may not be required to sign Section IV:

- For example, your relative would not be required to sign.
- However, if your representative is your provider or supplier, he or she is required to sign, because your Medicare issue might be related to a service that he or she provided or supplied to you. For example, they might have provided a service or medication that is not covered by Clear Spring Health. So, they need to agree that payment depends on resolution of the appeal.

When you and your representative have completed this form, please send it to:

Clear Spring Health
Attn: Enrollment
PO Box 3040
Spring Hill FL 34611
Fax: 1-866-643-6159
enrollmentdepartment@clearspringhealthcare.com

If you have any questions, please call our Member Services department at 1-877-364-4566. TTY users should call 711. We are open from October 1–March 31, seven days a week, 8:00 am –8:00 pm and from April 1 – September 30, Monday through Friday, 8:00 am – 8:00 pm (you may leave a voicemail Saturday, Sunday and Federal Holidays).

Thank you,
Clear Spring Health

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística llame al 1-877-364-4566 (TTY:711).

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

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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 of Party Seeking Representation:

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 of Party Seeking Representation:

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.

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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.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.