GEHA®

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AUTHORIZED REPRESENTATIVE DESIGNATION FOR CLAIMS

Please place a check mark in front of each plan you want this Authorized Representative designation to be applied. **(NOTE: At least one MUST be checked for this form to be valid.)**

☐ GEHA health plan (includes Connection Vision®) ☐ Connection Dental *Plus*® plan (includes Connection Vision®)

Subscriber name: _____ **GEHA ID number:** _____

Member name: _____ **Date of birth:** _____

Designated Authorized Representative name: _____
(Referred to as the "Representative." A contact person **must** be provided if this is an entity/organization.)

Representative complete address: _____

_____ **Representative phone number:** (___) _____

I hereby appoint my Representative as follows: (**NOTE: One box below MUST be checked for this form to be valid.)**

☐ **Limit my Representative to file/pursue only claims for the following provider, diagnosis, service/procedure, and/or dates of service.**

_____

OR

☐ **I designate my Representative to file/pursue all claims on my behalf.**

IMPORTANT: Your signature below also means that you understand and agree to the following:

- The information disclosed to the Representative may include protected health information you may consider to be sensitive, and may contain medical, pharmacy, dental, vision, mental health, substance, abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information.
- I understand that I may revoke the authorization at any time by notifying GEHA in writing at the address below. Revoking this authorization will not have any effect on actions GEHA took before receiving the revocation.
- GEHA will not condition treatment, payment, enrollment or eligibility for benefits based on this form.
- Information disclosed as based on this form may be further disclosed by the Representative without your authorization and may no longer be protected by federal or state privacy regulations.
- This Authorized Representative designation will automatically expire one year from the date it is signed, unless I otherwise specify a date or event:_____
Date or Event

Signature: _____ **Date:** _____
Member or Legal Representative (Proof of representation required)

Relationship, if not member: _____ **Signer's phone number:** _____
(e.g., self, parent, legal guardian, power of attorney, etc.)

Please retain a copy for your records and return the original signed form to:

GEHA Claims Department
P.O. Box 21542
Eagan, MN 55121