Grievance Authorized Representative Form

Claim Number: _____ Date of service: _____

This form allows another person to represent you during the grievance process. You DO NOT need to fill out this form if you are:
1) representing yourself in the grievance; 2) a parent or guardian of a minor child or disabled dependent, or 3) a court-appointed guardian.

You DO need to fill out this form if you are: 1) a health care provider; 2) the member's attorney or advocate; 3) a human resources representative or employer representative, or 4) a parent of a child who is over 18 years of age.

Return completed form to: Aspirus Health Plan, ATTN: Legal/Privacy, PO Box 1890, Southampton, PA 18966
or email to: CustomerService@aspirushealthplan.com. If you have questions, please call Customer Service at: 866.631.5404.

PART A: MEMBER INFORMATION

By signing this form in Part E below, I understand and agree that Aspirus Health Plan may release my protected health information as defined in Part B below to my Authorized Representative named in Part C below, and that such **Authorized Representative is authorized to file a grievance on my behalf, thereby exhausting my right to file such a grievance. This form must be filled out in its entirety. For purposes of this form, "grievance" is shorthand for grievances and appeals.**

Member Last Name	Member First Name	MI	Member Date of Birth
Member Street Address	**City**	**State**	**Zip Code**
Phone Number *(include area code)*	**Cell Number** *(include area code)*	**Subscriber Number** *(ID Card)*	

Note: This authorization does not provide your Authorized Representative with any authority, either implied or direct, over any treatment or direct care decisions. If you wish to designate an individual as your personal care representative to act on your behalf in making decisions regarding health care, please submit to Aspirus Health Plan a valid health care power of attorney, including any supporting documentation that may be needed to trigger application of the power of attorney (e.g., state of incapacity) or other valid document permitting such individual to make decisions related to your health care. **Aspirus Health Plan will not condition benefits payments, enrollment, or eligibility for benefits upon the execution of this form.**

PART B: TYPE OF INFORMATION *(WHAT IS BEING APPEALED OR GRIEVED)*

Describe the specific health information you are authorizing to be used or disclosed:

Limitations on disclosure: I understand that I have the right to limit the information that Aspirus Health Plan releases under this authorization. For example, I may limit my Authorized Representative's access to information about a particular health care provider or a particular diagnosis/disease. Any such limitations must be described in writing. I understand that if I leave this section blank, I am creating no limitation on disclosure. I am entitled to keep a copy of this form for my records.

PART C: GRIEVANCE AUTHORIZED REPRESENTATIVE INFORMATION

First Name	Last Name	Relationship to Customer	Phone Number *(include area code)*	Cell Number *(include area code)*
Mailing Address		**City**	**State**	**ZIP Code**

IMPORTANT!

All information and notifications from Aspirus Health Plan will be directed ONLY to the Authorized Representative named in this Part C, unless you direct otherwise below:

☐ All information and notifications should be distributed to me AND to my Authorized Representative listed above.

PART D: EXPIRATION AND REVOCATION

This authorization to release information to my Authorized Representative will automatically expire upon completion of the grievance filed on my behalf. I understand that I have the right to revoke this authorization at any time. I understand that if I do not wish the person named in Part C to remain my Authorized Representative, I must revoke this authorization by giving written notice of my decision to Aspirus Health Plan at the address listed above. I understand that my revocation of this authorization will not affect any action that Aspirus Health Plan has already taken, or any information that Aspirus Health Plan may have already released, based upon this authorization before Aspirus Health Plan actually received my request to revoke it.

PART E: MEMBER SIGNATURE OR AUTHORIZED REPRESENTATIVE/GUARDIAN

I understand that Aspirus Health Plan handles my protected health information as required by law. By signing this authorization, I agree that Aspirus Health Plan may discuss and disclose my protected health information to the person I name below for the purpose of filing, or assisting with, a Grievance. I understand that Aspirus Health Plan cannot control how my Authorized Representative uses my information once it is disclosed. I also understand that once my protected health information is released to a person who is not subject to federal or state privacy laws, that person may use or re-disclose my information in ways that Aspirus Health Plan cannot control. I acknowledge that my authorization is voluntary.

Member signature or Designated Legal Representative/Guardian signature	Date

If authorized representative: (1) print your name, (2) state the legal authority for your status as Member's representative, and (3) attach supporting documentation:*

*If you are the member's legally authorized representative as defined by HIPAA or other applicable federal and state law, you must submit the applicable documentation or other proof of legally authorized representative status that establishes your authority including but not limited to: **Power of Attorney** – Valid power of attorney document, **Guardian** – Valid court order appointing you as guardian, or **Executor** – Valid court order appointing you as executor of a decedent's estate. Legally authorized representatives must provide notice of any change to their status or authority.

Nondiscrimination & Language Access Policy

Discrimination is Against the Law. Aspirus Health Plan, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, (including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation, gender identity and sex stereotypes), consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2). Aspirus Health Plan, Inc. does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Aspirus Health Plan, Inc.:
Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

- Qualified sign language interpreters.
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

Provides free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters.
- Information written in other languages.

If *you* need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Nondiscrimination Grievance Coordinator at the address, phone number, fax number, or email address below.

If *you* believe that Aspirus Health Plan, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, *you* can file a *grievance* with:

Nondiscrimination Grievance Coordinator
Aspirus Health Plan, Inc.
PO Box 1890
Southampton, PA 18966-9998
Phone: 1-866-631-5404 (TTY: 711)
Fax: 763-847-4010
Email: customerservice@aspirushealthplan.com

You can file a *grievance* in person or by mail, fax, or email. If *you* need help filing a *grievance*, the Nondiscrimination Grievance Coordinator is available to help *you*.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. This notice is available at Aspirus Health Plan, Inc.'s website: https://aspirushealthplan.com/webdocs/70021-AHP-NonDiscrim_Lang-Assist-Notice.pdf.

Language Assistance Services

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë.Telefononi në 1-866-631-5404 (TTY: 711).

Arabic تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً. اتصل بن اعلى رقم الهاتف1-866-631-5404(رقم هاتف الصم والبك : 711)

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-631-5404 (ATS: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zurVerfügung. Rufnummer: 1-866-631-5404 (TTY: 711).

Hindi: _यान द_: य_द आप िहंदी बोलते ह_ तो आपके िलए मु_त म_ भाषा सहायता सेवाएं उपल_ध ह_। 1-866-631-5404 (TTY: 711) पर कॉल कर_।

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-866-631-5404 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.1-866-631-5404 (TTY: 711)번으로 전화해 주십시오.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer1-866-631-5404 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.Звоните 1-866-631-5404 (телетайп: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al1-866-631-5404 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nangwalang bayad. Tumawag sa 1-866-631-5404 (TTY: 711).

Traditional Chinese: 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 1-866-631-5404 (TTY: 711)

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-631-5404 (TTY: 711).

Pennsylvania Dutch: Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebbergricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-866-631-5404 (TTY: 711).

Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ,ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-866-631-5404 (TTY: 711).