Instructions: Completing the Designation of Representative/Authorization Form

This form is to be used for a grievance or an appeal and to allow a party to act as the Authorized Representative in carrying out a grievance or appeal.

If you have any questions, please feel free to call us at the customer service number on your member identification card.

Part A: Member Information

This section applies to the member who is asking for the release of his or her information to another person or company or a request to appoint an Authorized Representative. Please include as much information as you can.

1. Print your last name, first name, middle initial.
2. Write your date of birth in the format: mm/dd/yyyy (if you were born on October 1, 1965, you would write 10/01/1965).
3. Write your full street address, city, state, zip code.
4. Write your daytime phone number with area code.
5. Identification number: you will find this number on your member identification card.
6. Group number: you will find this number on your member identification card. If your identification card does not have a group number, leave this blank.

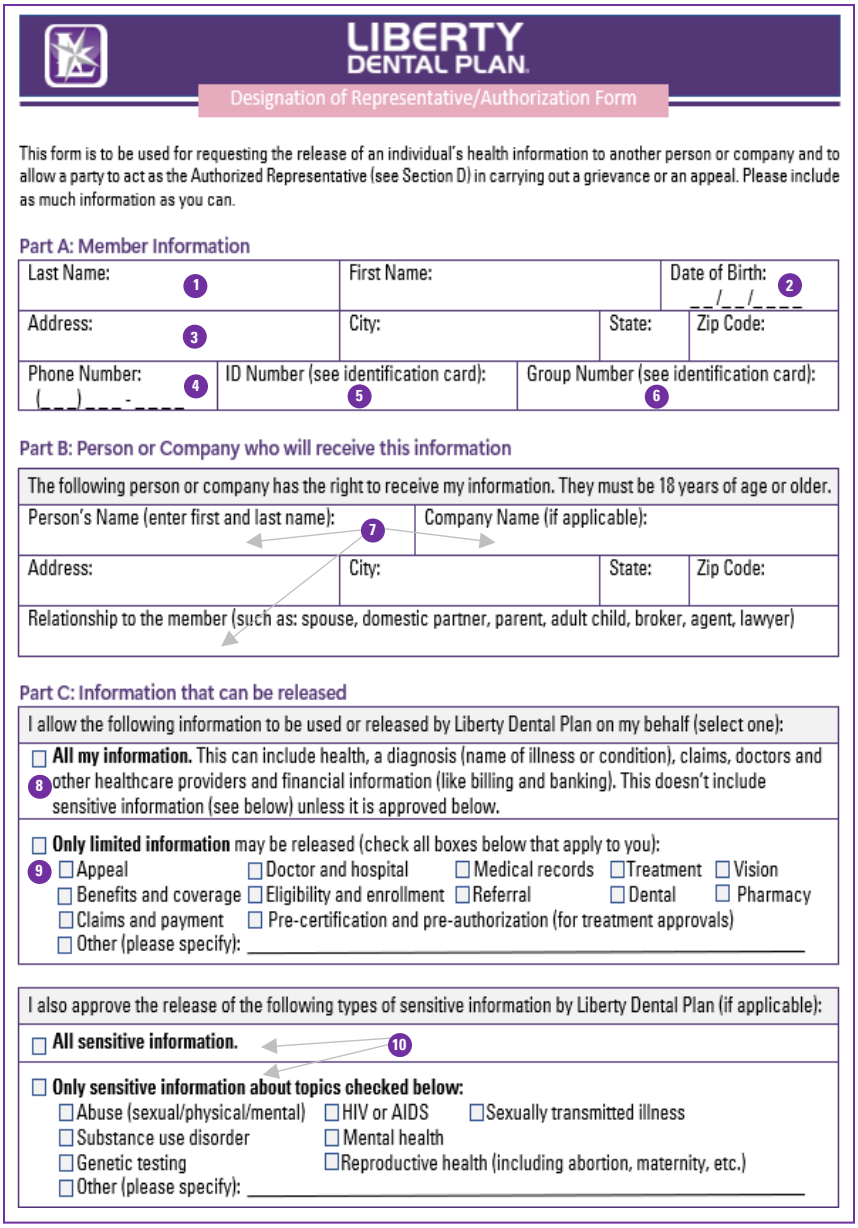
Part B: Person or company who can receive this information

7. Write the full name of the person or company that you want us to give your information to. Specify the type of relationship relating to the member.

Part C: Information that can be released

This section tells us what information you would like us to release: all or limited.

8. For "all my information," check the first box. This does not include sensitive information.
9. For "only limited information," check the second Box and each of the boxes that apply to you.
10. Some topics may be very personal or sensitive to you. If you wish to approve the release of this type of information, check the "All sensitive information" or "Only sensitive information about topics" and check each box that applies.



LIBERTY DENTAL PLAN

Designation of Representative/Authorization Form

This form is to be used for requesting the release of an individual's health information to another person or company and to allow a party to act as the Authorized Representative (see Section D) in carrying out a grievance or an appeal. Please include as much information as you can.

Part A: Member Information

Last Name: 1	First Name:	Date of Birth: 2 __/__/____
Address: 3	City:	State: / Zip Code:
Phone Number: 4 (___)___-____	ID Number (see identification card): 5	Group Number (see identification card): 6

Part B: Person or Company who will receive this information

The following person or company has the right to receive my information. They must be 18 years of age or older.

Person's Name (enter first and last name): 7	Company Name (if applicable):
Address:	City: / State: / Zip Code:
Relationship to the member (such as: spouse, domestic partner, parent, adult child, broker, agent, lawyer)	

Part C: Information that can be released

I allow the following information to be used or released by Liberty Dental Plan on my behalf (select one):

8 ☐ **All my information.** This can include health, a diagnosis (name of illness or condition), claims, doctors and other healthcare providers and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below.

9 ☐ **Only limited information** may be released (check all boxes below that apply to you):
☐ Appeal ☐ Doctor and hospital ☐ Medical records ☐ Treatment ☐ Vision
☐ Benefits and coverage ☐ Eligibility and enrollment ☐ Referral ☐ Dental ☐ Pharmacy
☐ Claims and payment ☐ Pre-certification and pre-authorization (for treatment approvals)
☐ Other (please specify): _____

I also approve the release of the following types of sensitive information by Liberty Dental Plan (if applicable):

☐ **All sensitive information.** 10

☐ **Only sensitive information about topics checked below:**
☐ Abuse (sexual/physical/mental) ☐ HIV or AIDS ☐ Sexually transmitted illness
☐ Substance use disorder ☐ Mental health
☐ Genetic testing ☐ Reproductive health (including abortion, maternity, etc.)
☐ Other (please specify): _____

Please read the following for help completing page two of the form.

Part D: Person or company who can act as my authorized representative

This section tells us who you have given the right to act as your Authorized Representative in carrying out a grievance or appeal. Part B and C must also be completed to authorize the release of your information.

1. Write the full name of the person or company that you want to act as your Authorized Representative. List a phone number, fax number, or email address if one is available. Specify the type of relationship relating to the member.

Part E: Date your approval expires

You have two choices of when you would like this approval to end.

2. Check the first box for the conclusion of the grievance or appeal process.
3. Check the second box for an earlier date (date will come from Part G signature date).

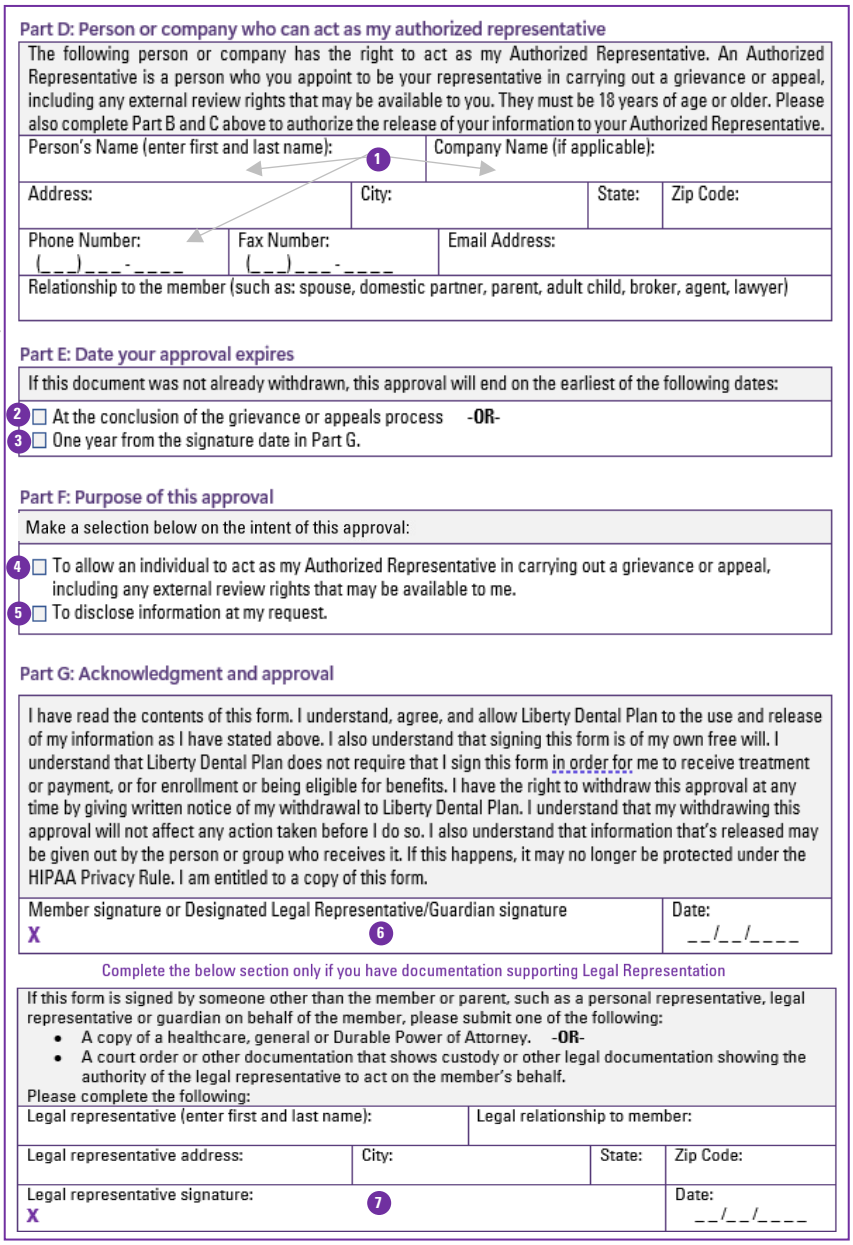
Part F: Purpose of this approval

This section tells us the reason you've asked For the release of your information.

4. Check the first box to let us know who to give out this information as shown on this form.
5. Check the second box to let us know what Information to give out (identified in Part C).

Part G: Acknowledgment and approval

6. **Sign your name and put the date on the form.** Your name and signature must match the Information in Part A.
7. **If you are signing this form on behalf of another Person, or if you have Power of Attorney for Healthcare, or are a legal guardian/conservator You must do the following:**
   - You must complete the Designated Legal Representative/Guardian section.
   - You must also provide us with a copy of the legal document showing that you are approved and include it with this form.



Part D: Person or company who can act as my authorized representative

The following person or company has the right to act as my Authorized Representative. An Authorized Representative is a person who you appoint to be your representative in carrying out a grievance or appeal, including any external review rights that may be available to you. They must be 18 years of age or older. Please also complete Part B and C above to authorize the release of your information to your Authorized Representative.

Person's Name (enter first and last name): 1	Company Name (if applicable):		
Address:	City:	State:	Zip Code:
Phone Number: (___)___-____	Fax Number: (___)___-____	Email Address:	
Relationship to the member (such as: spouse, domestic partner, parent, adult child, broker, agent, lawyer)			

Part E: Date your approval expires

If this document was not already withdrawn, this approval will end on the earliest of the following dates:

2 ☐ At the conclusion of the grievance or appeals process -OR-
3 ☐ One year from the signature date in Part G.

Part F: Purpose of this approval

Make a selection below on the intent of this approval:

4 ☐ To allow an individual to act as my Authorized Representative in carrying out a grievance or appeal, including any external review rights that may be available to me.
5 ☐ To disclose information at my request.

Part G: Acknowledgment and approval

I have read the contents of this form. I understand, agree, and allow Liberty Dental Plan to the use and release of my information as I have stated above. I also understand that signing this form is of my own free will. I understand that Liberty Dental Plan does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits. I have the right to withdraw this approval at any time by giving written notice of my withdrawal to Liberty Dental Plan. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Member signature or Designated Legal Representative/Guardian signature 6 X	Date: __/__/____

Complete the below section only if you have documentation supporting Legal Representation

If this form is signed by someone other than the member or parent, such as a personal representative, legal representative or guardian on behalf of the member, please submit one of the following:
- A copy of a healthcare, general or Durable Power of Attorney. -OR-
- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.

Please complete the following:

Legal representative (enter first and last name):	Legal relationship to member:		
Legal representative address:	City:	State:	Zip Code:
Legal representative signature: 7 X			Date: __/__/____

Examples of legal documents:

- **Health Care, General or Durable Power of Attorney.** This document gives someone you trust the legal power to act on your behalf and make health care decision for you.
- **Legal Guardianship.** This is when the court appoints someone to care for another person.
- **Conservatorship.** This happens when a judge appoints a responsible person to make decisions for someone who can't make responsible decisions for him/herself.
- **Executor of estate.** This type of document would be used when the person who is being represented has died.

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Part A: Member Information

Last Name:	First Name:		Date of Birth: _ _/_ _/_ _ _ _
Address:	City:	State:	Zip Code:
Phone Number:	ID Number (see identification card):	Group Number (see identification card):	

Part B: Person or Company who will receive this information

The following person or company has the right to receive my information. They must be 18 years of age or older.

Person's Name (enter first and last name):	Company Name (if applicable):		
Address:	City:	State:	Zip Code:
Relationship to the member (such as: spouse, domestic partner, parent, adult child, broker, agent, lawyer)			

Part C: Information that can be released

I allow the following information to be used or released by Liberty Dental Plan on my behalf (select one):

☐ **All my information.** This can include health, a diagnosis (name of illness or condition), claims, doctors and other healthcare providers and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below.

☐ **Only limited information** may be released (check all boxes below that apply to you):

☐ Appeal ☐ Doctor and hospital ☐ Medical records ☐ Treatment ☐ Vision
☐ Benefits and coverage ☐ Eligibility and enrollment ☐ Referral ☐ Dental ☐ Pharmacy
☐ Claims and payment ☐ Pre-certification and pre-authorization (for treatment approvals)
☐ Other (please specify): _____

I also approve the release of the following types of sensitive information by Liberty Dental Plan (if applicable):

☐ **All sensitive information.**

☐ **Only sensitive information about topics checked below:**

☐ Abuse (sexual/physical/mental) ☐ HIV or AIDS ☐ Sexually transmitted illness
☐ Substance use disorder ☐ Mental health
☐ Genetic testing ☐ Reproductive health (including abortion, maternity, etc.)
☐ Other (please specify): _____

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The following person or company has the right to act as my Authorized Representative. An Authorized Representative is a person who you appoint to be your representative in carrying out a grievance or appeal, including any external review rights that may be available to you. They must be 18 years of age or older. Please also complete Part B and C above to authorize the release of your information to your Authorized Representative.

Person's Name (enter first and last name):		Company Name (if applicable):	
Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:	Email Address:	
Relationship to the member (such as: spouse, domestic partner, parent, adult child, broker, agent, lawyer)			

Part E: Date your approval expires

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☐ At the conclusion of the grievance or appeals process **-OR-**
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Part F: Purpose of this approval

Make a selection below on the intent of this approval:

☐ To allow an individual to act as my Authorized Representative in carrying out a grievance or appeal, including any external review rights that may be available to me.
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Member signature or Designated Legal Representative/Guardian signature	Date:
X	_ _/_ _/_ _ _ _

Complete the below section only if you have documentation supporting Legal Representation

If this form is signed by someone other than the member or parent, such as a personal representative, legal representative or guardian on behalf of the member, please submit one of the following:

- A copy of a healthcare, general or Durable Power of Attorney. **-OR-**
- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.

Please complete the following:

Legal representative (enter first and last name):	Legal relationship to member:		
Legal representative address:	City:	State:	Zip Code:
Legal representative signature: **X**			Date: _ _/_ _/_ _ _ _

Please return the completed form to:

Liberty Dental Plan
Quality Management Department
Attn: Grievances and Appeals
P.O. Box 26110
Santa Ana, CA 92799-6110
Fax: 1-833-250-1814

Keep a copy of this form for your records.

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