

**Humana**  
**Grievance and Appeal Department**  
**APPOINTMENT OF AUTHORIZED REPRESENTATIVE FORM**

\_\_\_\_\_  
**Member Name**

\_\_\_\_\_  
**Member ID Number** (to be completed by member)

I, \_\_\_\_\_, appoint  
Name of Member

Stephanie Stuart  
Name of Authorized Representative

to act on behalf of \_\_\_\_\_  
Name of Member

in connection with any claim for coverage or benefits identified in case # \_\_\_\_\_ including receipt of any approval(s) or authorization(s) that are required before medical service(s). I authorize my representative to receive any, and all information related to this case that is provided to me, and to act for me and for my minor dependent, if named above, in providing any information to the group health plan in relation to the disputed claims, approvals, or authorizations. This document is not intended to authorize access to any personal health information unrelated to the disputed claims, approvals, or authorizations.

\_\_\_\_\_  
**Signature of Member\***

\_\_\_\_\_  
**Date\***

Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I, Stephanie Stuart, hereby accept the above appointment.  
Name of Authorized Representative

I am a/an A/R Analyst  
Relationship to member

Stephanie Stuart  
**Signature of Authorized Representative**

\_\_\_\_\_  
**Date**

Address: Shreveport Sedation Associates Telephone Number: 888-337-3509  
PO Box 865661  
Orlando FL 32886

\* The date of the member's signature must be on or after the denial of the disputed claims, approvals, or authorizations. An electronic signature is not a valid signature.