Personal Representative Authorization Form
Filing an Appeal

This form allows Medicare Advantage Plan members to designate a person who is authorized to file an appeal on their behalf. This person is called a Personal Representative. You do not need to fill out this form if you would like to notify FCHP of a legal representative, such as a durable power of attorney, guardian or health care proxy. Simply submit a copy of this legal document to FCHP at the address listed at the end of this form and it will be reviewed.

Member information

Member name:	Medicare beneficiary number:
Member ID number:	Member telephone number:
Member address:	

Personal Representative information

Personal Representative name:	Personal Representative relationship to member:
Personal Representative telephone number:	Personal Representative address:

I authorize my Personal Representative 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 appeal, wholly in my place.

- I understand that my authorization to allow my Personal Representative to file an appeal on my behalf **will expire one year from the date both I and my Personal Representative sign this form.** Also, the representation is valid for the duration of an appeal, if the appeal is filed prior to the expiration date of this form.
- I understand that while acting on my behalf for appeals, my Personal Representative will have access to all personal information about me, both financial and medical, that is necessary to represent me with my appeal.

Member's signature: ______________________________________ **Date:** ____________________________

Acceptance of Appointment: Must be signed by the Personal Representative in order for the appointment to be effective.

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; I am not, as a current or former employee of the United States, disqualified from acting as a representative of a beneficiary under a federal government program. I recognize that any fee may be subject to review and approval by the Secretary.

Personal Representative's
signature: ____ Date: _____________________________

Waiver of Fee for Representation: To be completed by the Personal Representative only if the representative waives a fee for such 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 the member named above before the Secretary of the Department of Health and Human Services.

Personal Representative's
signature: ____ Date: ______________________________

Waiver of Payment for Items or Services at Issue: To be completed by the Personal Representative only if the representative is a provider or supplier and 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, and 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.

Personal Representative's
signature: ____ Date: _____________________________

Mail or fax completed form to:
Privacy Coordinator • Fallon Community Health Plan • 10 Chestnut St. • Worcester, MA 01608
Fax 1-508-831-1136

Charging of fees for representing beneficiaries before the Secretary of the Department of Health and Human Services (DHHS)

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 the Department of Health and Human Services (DHHS) (i.e., the Administrative Law Judge (ALJ) hearing, Medicare appeals Council (MAC) review, or a proceeding before an ALJ or the MAC 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 or request for MAC 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.

Authorization of fee

The requirement for the approval of fees ensures that representative will receive fair value for the services performed before DHHS 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, the ALJ or MAC considers the nature and type of services performed, 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 DHHS.

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 if you are filing a grievance, initial determination or decision if you are requesting an initial determination or decision.

If additional help is needed, contact your Medicare plan or 1-800-MEDICARE (1-800-633-4227).

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