UnitedHealthcare
PO Box 30555
Salt Lake City, UT 84130
October 14, 2010

Member Authorization Form for a Designated Representative to Appeal a Determination

DATE: _____

Member Name: _____

Member#: _____

I hereby authorize **The Midwives of NJ, LLC** to appeal UnitedHealthcare's determination concerning _____ on my behalf, as my Designated Representative, and, as part of the appeal, I hereby authorize UnitedHealthcare in its decision letter and in connection with the processing of my appeal, to communicate with my Designated Representative in all aspects of the appeal. I understand that these communications may contain the following:

> All medical and financial information contained in my insurance file, including but not limited to treatment for venereal disease, alcoholism and drug abuse, abortion, mental disorder and HIV status relating to my examination, treatment and hospital confinement in connection with the determination which is being appealed.

I understand this information is privilaged and confidential and will only be released as specified in this authorization, or as required or permitted by law. This authorization is valid for a period of one year.

_____
Signature of Member or Legal Guardian/Representative

_____
_____ Signature of Witness __X__ Designated Representative (Check one)

_____
Name of Witness/Designated Representative (Please Print)

_____
Title (if on provider's staff) or Relationship to Member