OXFORD HEALTH PLANS®
A UnitedHealthcare Company

Member Authorization Form for a Designated Representative to Appeal a Determination

TO: Clinical Appeals Department
48 Monroe Turnpike
Trumbull, CT 06611

DATE: _____

Member Name: _____

Member ID #: _____

I hereby authorize ***The Midwives of NJ, LLC*** to appeal Oxford's determination
(*print name*)

concerning _____ on my behalf, as my
(*description of service and date of Oxford's determination or reference number*)
Designated Representative, and, as part of the appeal, I hereby authorize Oxford in its decision letter and in connection with the processing of my appeal, to communicate with my Designated Representative concerning 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 privileged and confidential and will only be released as specified in this Authorization. This authorization is valid for a period of one year.

_____
Signature of Member or Legal Guardian/Representative

_____
___Signature of Witness ___Designated Representative (Check One)

_____
Name of Witness/Designated Representative (Please Print)

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