



## 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