Appointment of Authorized Representative for Appeal

This form allows a participant in a health plan administered by Quartz to choose someone to act on their behalf in pursuing an appeal.

Please complete the form and return it by mail to Quartz Align, Attn.: Appeals, P.O. Box 8085, Garden City, NY 11530, or by fax to (516) 723-7390.

Participant

Name: _____ ID number: _____

Appeal information

Name of service: _____ Provider name: _____

Date of service: _____ Location of service: _____

Authorized representative

Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone: _____ Email: _____

Authorization

I, _____ (participant), hereby appoint _____ (authorized representative) to act on my behalf in connection with the appeal of the above noted service. I authorize my representative to receive any and all information that is provided to me and to act for me in providing any information to Quartz and/or my group health plan that relates to the appeal.

Note: All information and notifications from Quartz and/or your group health plan will be directed to your authorized representative and to you, unless you direct otherwise by checking the applicable box below.

- ☐ Distribute only to me
- ☐ Distribute only to my authorized representative

This authorization is only valid for the duration of the appeal. If you sign this form, you may revoke the authorization at any time by notifying Quartz in writing at the above address.

Signature of participant or legal representative: _____

Date: _____ Printed name: _____