Appointment of Authorized Representative Form

You may represent yourself, or you may ask another person, including your treating health care provider, to act as your authorized representative. You may revoke this authorization at any time.

Authorized Representative Info

Name: _____

Mailing Address: _____

Daytime Phone: _____

Evening Phone: _____

Email: _____

Fax: _____

I hereby authorize _____ to pursue my external appeal on my behalf.

_____ _____

Signature of Covered Person (or legal representative) Date

Physician Certification for Expedited External Appeal

I hereby certify that I am a treating physician for _____ (hereafter referred to as "the covered person"); that adherence to the time frame for conducting a standard external appeal would, in my professional judgment, seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and that, for this reason, the covered person's external appeal should be processed on an expedited basis.

_____

Treating Physician Printed Name

_____ _____

Signature Date

Authorization For Release Of Confidential Information In Support Of Appeal

In order for us to disclose your information to another entity, you must complete and sign this form and return it to us with your external appeal application to:

Fax: 844-965-9054

Mail: Cigna + Oscar c/o Oscar Management Corporation
Attn: External Appeals
PO Box 52146
Phoenix, AZ 85072

Name: _____ Date of Birth: _____

ID#: _____

I authorize Oscar Management Corporation, acting as delegated by Cigna Health and Life Insurance Company, to release all records and information pertinent to this grievance or appeal so Oscar Management Corporation can process my request for grievance or appeal. This includes records and information related to 'sensitive' health information such as HIV/AIDS, mental/behavioral health, and substance use disorders. I authorize Oscar Management Corporation to release records and information pertinent to this grievance or appeal to any third party they deem necessary.

I understand that once my information is disclosed pursuant to this authorization, the information may no longer be protected by federal and state privacy standards and my health information may be re-disclosed. I have the right to revoke (cancel) this authorization at any time by sending a written notice at the addresses listed at the top of this form. I understand the revocation will not be effective until it is received. I am aware that my revocation will mean that I may no longer be eligible for the grievance or appeal process since this information may be necessary to perform the process. I also understand that a copy of this form may be considered as valid as the original. This release of information expires in 20 days following completion or termination of the grievance/appeals process.

If I am authorizing a representative to serve for me in the grievance/appeal process, I understand that I must also complete a form confirming that representation.

I have read and understood the terms of this form.

_____ _____
(Covered Person's signature) (Day/Month/Year)

If the Covered Person is unable to give consent because of physical condition or age, complete the following and attach legal documentation supporting your ability to act on the Covered Person's behalf.

Covered Person is a minor _____ years of age or is unable to give consent due to:

_____.

_____ _____
(Authorized Representative's signature) (Day/Month/Year)