

Appointment of Authorized Representative (AOR) Form

Alameda Alliance for Health (Alliance) members have the right to authorize (give) a friend, family member, or another person access to certain medical information about them. To exercise this member right, please use this form to appoint an individual to be an authorized representative for the Alliance member.

Instructions

1. Please print clearly or type in all the fields below.
2. Submit the completed form in person, by mail, fax, or email.

For Alliance Group Care and Medi-Cal members:

In person/by mail:

Attn: Member Services Department
Alameda Alliance for Health
1240 South Loop Road
Alameda, CA 94502

Fax: **1.877.747.4504**

Email: **memberservices@alamedaalliance.org**

For Alameda Alliance Wellness (HMO D-SNP) members:

In person/by mail:

Attn: Alameda Alliance Wellness Member Service Department
Alameda Alliance Wellness
1240 South Loop Road
Alameda, CA 94502

Fax: **1.877.747.4504**

Email: **DeptAAWMemberSupport@alamedaalliance.org**

Section 1: Alliance Member Information

Tell Us About You

Last Name: _____ First Name: _____

Alliance Member ID Number (Alliance Group Care or Medi-Cal, or Alameda Alliance Wellness):

Medi-Cal ID Number (if eligible, and known): _____

Medicare ID Number (if eligible, and known): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ ☐ Home ☐ Cell

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Section 2: Authorized Representative Information

Tell Us About Your Representative

Last Name: _____ First Name: _____

Relationship to the Member: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ ☐ Home ☐ Cell

Section 3: Authorized Representative Duties

This appointment allows the authorized representative to act on behalf of the member for the following Alliance services:

- Change my doctor/medical group
- File a grievance or appeal
- Order a new Alliance member ID card
- Speak to the Alliance to assist in the coordination of the member's medical care
- Authority to act on prescription drug (Part D) matters

Section 4: Authorization for Sensitive Information (Optional)

This appointment also includes authority to act on information related to my care for **sensitive services**, which may include mental health, reproductive health, substance use treatment, gender-affirming care, or other protected categories. I understand that this authorization is voluntary and can be revoked at any time.

- ☐ **Yes**, I authorize my representative to act on sensitive information matters.
- ☐ **No**, I do not authorize my representative to act on sensitive information matters.

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Section 5: Authorized Representative Acceptance

Read and Sign

I have read this form and understand that:

- An appointment of a representative is valid for one (1) year from the date this form is submitted. The Alliance member may revoke this appointment at any time and appoint another individual(s) to act as their authorized representative.
- I have no other power to act on the member's behalf, except for the Alliance services as stated in Section 3 and Section 4.
- I may not transfer or reassign my appointment.
- I may stop (revoke) this appointment at any time by sending a written request to the Alliance.
- I agree to follow all state and federal laws governing authorized representatives. Including, but not limited to, laws about the privacy of information, rules against reassigning provider claims, and conflicts of interest.
- Waiver of Fee for Representation (for providers only): Providers and suppliers who furnished the items or services under an AOR are not permitted to charge a fee for representation and, by signing, they formally waive any right to such fees.
 - I agree not to charge the member or anyone else for representing them in this matter.

Representative/Organization Name:

National Provider Identifier (NPI) (if provider):

- Waiver of Payment for Appeals under § 1879(a)(2): Only required if you're a provider or supplier who gave the services being appealed.
 - I agree not to seek payment from Medicare or the member for the items or services in question if it's decided that Medicare shouldn't pay under § 1879(a)(2).

Representative/Organization Name:

National Provider Identifier (NPI) (if provider):

By signing below, I hereby accept this appointment.

Authorized Representative's Signature: _____ Date: _____

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Section 6: Purpose & Member Rights

Read and Sign

I have read this form and understand that:

- By filling out this appointment, I agree to have my authorized representative act on my behalf for the services as stated in Section 3 and Section 4.
- My rights and responsibilities as a member of the Alliance do not change because I have an authorized representative.
- I understand that once the information is disclosed pursuant to this authorization, it might be re-disclosed by the recipient, and the information may not be protected by federal or state privacy regulations.
- I am aware that I may stop (revoke) this appointment at any time by sending a written request to the Alliance in person, by mail, fax, or email.

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Alameda Alliance Wellness
1240 South Loop Road
Alameda, CA 94502

Fax: **1.877.747.4504**

Email: **DeptAAWMemberSupport@alamedaalliance.org**

By signing below, I hereby authorize this appointment, effective on the date of signing.

Signature: _____ Date: _____

Relationship if signing on behalf of the member: _____

If signing on behalf of the member, you must provide documentation that authorizes you to be the member's personal representative, along with this form. (For example, Health Care Power of Attorney, Letters of Conservatorship, etc.)