Appointment of Authorized Representative (AOR) Form

As a member of Alameda Alliance for Health (Alliance), you have the right to authorize (give) a friend, family member, or another person you identify access to certain medical information about you.

To exercise this member right, you must **complete all fields** of this form and mail, fax, or email it to:

Attn: Member Services Department
Alameda Alliance for Health
1240 South Loop Road
Alameda, CA 94502
Fax: **1.877.747.4504**
Email: **memberservices@alamedaalliance.org**

Section 1: Tell Us About You

Alliance Member

Last Name: _____ First Name: _____

Phone Number: _____

Alliance Member ID Number (*Group Care, Medi-Cal, or Medicare*):

_____

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

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

Address: _____

City: _____ State: _____ Zip Code: _____

Section 2: Tell Us About Your Representative

Name of Authorized Representative

Last Name: _____ First Name: _____

Phone Number: _____ Relationship to You (Member): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Section 3: My Representative Can Do the Following

This appointment allows my authorized representative to act on my behalf 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 on my behalf to assist in the coordination of my medical care
- This appointment also includes 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.

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 above 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) Number (if provider):

_____

Section 5: Authorized Representative Acceptance (cont.)

Read and Sign (cont.)

- 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).2).

Provider/Supplier Name:

_____

National Provider Identifier (NPI) Number (if provider):

_____

By signing below, I hereby accept this appointment.

Authorized Representative's Signature: _____ Date: _____

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 selected above 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 at:

Attn: Member Services Department
Alameda Alliance for Health
1240 South Loop Road
Alameda, CA 94502
Fax: **1.877.747.4504**

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.)