MERITAIN® HEALTH
An Aetna Company

MERITAIN HEALTH® APPEALS AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Group Health Plan:
Claimant's Alternate ID:

Appointment of Authorized Representative for Meritain Appeal

I, _____, hereby appoint _____
([Name of Claimant]) (Authorized Representative)

to act on my behalf in connection with the appeal for claim(s) **for date(s) of service** _____ for coverage or benefits, including receipt of any approvals or authorizations that are required before medical services are provided under the plan named above ("Plan"). I authorize my representative to file appeals on my behalf in connection with the appeal for claim(s) for date(s) of service specified above for coverage or benefits. I authorize my representative to receive all information that is provided to me and to act for me (or my dependent, if named above as the patient), in providing any information to the Plan that relates to the appeal for claim(s) for date(s) of service specified above for coverage or benefits under the Plan.

IMPORTANT: All information and notifications from the Plan related to the appeal will be directed to the authorized representative appointed through this form and not to you, unless you direct otherwise by checking below:

☒ Distribute to my authorized representative and me: All information and notifications should be distributed to my authorized representative and me.

_____ _____
Claimant Signature **Date**

Please return to:
Meritain Health Appeals Department
PO Box 41980
Plymouth, MN 55441