This attached form can be used by Medicare enrollees to authorize a representative to act on their behalf to submit a request for an organization determination to CareCentrix. Please return the completed form to CareCentrix using one of the following communication channels:

**Mail Completed Form To:**
**CareCentrix, Inc.**
***Attention: Fax Screening Team***
**919 Corporate Lake Drive Suite 200**
**Tampa, FL 33634**

**Fax Completed Form To:**
**(866) 536-8046**

**Email Completed Form To:**
**medicareappointmentofrepresentative@carecentrix.com**

Form Approved
OMB No. 0938-0950
Expires: 12/31/2028

Department of Health and Human Services
Centers for Medicare & Medicaid Services

# Appointment of Representative

Use this form to appoint a representative to act on your behalf for your claim, appeal, grievance or request. By signing this form and appointing this representative, you agree that the representative will be the main contact and have authority to make requests, present evidence, get information, and receive all communication about your action. This person may see your personal medical information. **All fields in Sections 1 and 2 are required unless marked optional.**

## Section 1: Information about the person appointing the representative

**This section must be completed by the patient, provider or other person appointing a representative.**

| Name | Medicare Number or National Provider Identifier |
|---|---|
| Mailing address | Phone number (with area code) ( ) - |
| City | State / ZIP code |
| Email (optional) | Fax (optional) ( ) - |
| Signature | Date signed (mm/dd/yyyy) / / |

## Section 2: Information about the representative

**This section must be completed by the representative.**

Representative Name

Professional status or relationship to the person in Section 1 (attorney, relative, etc.)

| Mailing address | Phone number (with area code) ( ) - |
|---|---|
| City | State / ZIP code |
| Email (optional) | Fax (optional) ( ) - |

By signing below, you agree to act as a representative and certify that you haven't been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS) or otherwise disqualified from acting as a representative. Any fee to be charged for acting as a representative may be subject to review and approval by the Secretary. If you're charging a fee, go to instructions on page 2.

| Signature | Date signed (mm/dd/yyyy) / / |
|---|---|

**Representative must complete the sections below, if applicable** (go to instructions on page 2)

## Section 3: Waiver of fee for representation

Providers and suppliers who furnished the items or services at issue can't charge a fee for representation and must sign below to waive their fee. Representatives who choose to waive their fee for representation must also sign below.

**I waive my right to charge and collect a fee for representing the person in Section 1 before the Secretary of HHS.**

| Signature | Date signed (mm/dd/yyyy) / / |
|---|---|

## Section 4: Waiver of payment for items or services at issue

If you're a provider or supplier and you furnished items or services to the patient you're representing, if the appeal involves a question of whether you or the patient didn't know, or couldn't reasonably be expected to know, that Medicare wouldn't cover the items or services.

**I waive my right to collect payment from the patient for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is made.**

| Signature | Date signed (mm/dd/yyyy) / / |
|---|---|

# Instructions and Regulation Requirements

## Instructions

All fields in Sections 1 and 2 are required unless marked "optional." If the person or entity appointing a representative doesn't have a Medicare number or National Provider Identifier, fill in "not applicable." Go to the regulation at 42 CFR 405.910: ECFR.gov/current/title-42/chapter-IV/subchapter-B/part-405/subpart-I/section-405.910

Waiver of Fee for Representation Section 3 is required when a representative is required, or has agreed, to waive or not charge a fee for their representation. Waiver of Payment for Items or Services at Issue Section 4 is required if a provider or supplier who furnished items or services to the patient represents the patient and liability (knowledge of non-coverage) under §1879(a)(2) of the Act is at issue in the appeal. Go to 42 CFR 405.910(f).

An appointment of a representative is considered valid for one year from the date this form is signed by both the person appointing a representative and the appointed representative. A completed form can be used for other appeals or actions during the one-year period it's valid. Unless revoked, the representation is valid for the duration of the claim, appeal, grievance, or request for which it was filed.

## Where to send this form

If you have Original Medicare, and you wish to appoint a representative to act on your behalf for your claim, appeal, grievance or request, send this form to the address located on your Medicare Summary Notice (MSN). If you no longer have your MSN, please call 1-800-MEDICARE (1-800-633-4227) to get the address.

If you have a Medicare Advantage plan and you wish to appoint a representative to act on your behalf for your claim, appeal, grievance or request, contact member services at your plan to find out where to send this form. The number for your plan's member services can be found on your Evidence of Coverage or on your Member ID card.

If you wish to appoint a representative to act on your behalf for your Medicare Prescription drug claim, appeal, grievance or request, contact member services at your plan to find out where to send this form. The number for your plan's member services can be found on your Evidence of Coverage or on your Member ID card.

## Get help & more information

For questions about this form, contact your Medicare plan or call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

You have the right to get Medicare information in an accessible format, like large print, braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice, or call 1-800-MEDICARE for more information.

## Charging fees for representing patients before the Secretary of HHS

An attorney, or other representative for a patient, who wants to charge a fee for services rendered in connection with an appeal before the Secretary of HHS (i.e., an Administrative Law Judge (ALJ) hearing or attorney adjudicator review by the Office of Medicare Hearings and Appeals (OMHA), Medicare Appeals Council review, or a proceeding before OMHA or the Medicare Appeals Council as a result of a remand from federal district court), is required to have the fee approved in accordance with 42 CFR 405.910(f).

The representative should complete the form OMHA-118, "Petition to Obtain Approval of a Fee for Representing a Beneficiary" and file it with the request for ALJ hearing, OMHA review, or request for Medicare Appeals Council review. Fee approval is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court-appointed representative, and the court approved the fee; (3) the fee is for representing a patient in a proceeding in federal district court; or (4) the fee is for representing a patient in a redetermination or reconsideration. Representatives are permitted to waive their fee if they choose. Get form OMHA-118 here: HHS.gov/sites/default/files/OMHA-118.pdf

A provider or supplier who furnished the items or services to a Medicare patient that are the subject of the appeal may represent that patient in an appeal, but the provider or supplier may not charge the beneficiary any fee associated with the representation. (42 CFR 405.910(f)(3).)

## Approval of fee

The fee approval requirement ensures that a representative is paid fairly for their services and that patient fees are reasonable. In approving a requested fee, OMHA or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required, the amount of time spent on the case, the results achieved, the level of administrative review needed, and the amount of the fee requested.

## Conflict of interest

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain current and former officers and employees of the United States to render certain services in matters affecting the government or to aid or assist in prosecuting claims against the United States. Individuals with a conflict of interest are excluded from serving as representatives of patients before HHS.

---

**Paperwork Reduction Act:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. **NOTE:** Please do not send this form directly to CMS. Follow the instructions in the "Where to send this form" section.

## Notice of availability of language assistance services and auxiliary aids and services

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-833-592-1093. Someone who speaks English can help you. The call is free. We also provide free auxiliary aids and services, such as large print, braille, or audio. Just call us at the number above to make this request.

**Spanish:** Contamos con servicios de intérprete gratuitos para responder cualquier pregunta que tenga sobre nuestro plan de salud o medicamentos. Para obtener un intérprete, solo llámenos al 1-833-592-1093. Alguien que habla español podrá ayudarle. La llamada es gratuita. También ofrecemos ayudas y servicios auxiliares gratuitos, como impresión en letra grande, braille o audio. Solo llámenos al número mencionado arriba para hacer esta solicitud.

**Chinese:** 我們提供免費口譯服務，以解答您有關我們的健康或藥物計劃的任何問題。如需口譯服務，請撥打 1-833-592-1093。會有說中文的人為您提供幫助。此為免付費電話。我們也提供免費的輔助工具和服務，例如大號字體印刷版、盲文或音訊。請撥打上述電話向我們提出請求。

**French:** Nous disposons de services d'interprétation gratuits pour répondre à toutes les questions que vous pourriez avoir sur notre régime de santé ou d'assurance médicaments. Pour obtenir un interprète, il vous suffit de nous appeler au 1-833-592-1093. Une personne parlant français pourra vous aider. L'appel est gratuit. Nous fournissons également gratuitement des aides et des services auxiliaires, tels que des documents en gros caractères, en braille ou audio. Il vous suffit de nous appeler au numéro ci-dessus pour en faire la demande.

**Vietnamese:** Chúng tôi cung cấp dịch vụ thông dịch miễn phí để giải đáp mọi thắc mắc liên quan đến chương trình bảo hiểm sức khỏe hoặc chương trình thuốc của chúng tôi. Để yêu cầu chúng tôi bố trí thông dịch viên, vui lòng gọi điện đến số 1-833-592-1093. Một nhân viên nói tiếng Việt sẽ hỗ trợ quý vị. Cuộc gọi này hoàn toàn miễn phí. Chúng tôi cũng cung cấp các công cụ và dịch vụ hỗ trợ miễn phí, chẳng hạn như bản in khổ chữ lớn, chữ nổi Braille hoặc băng thu âm. Quý vị chỉ cần gọi cho chúng tôi theo số điện thoại bên trên để yêu cầu các dịch vụ này.

**Korean:** 저희는 건강 플랜 또는 의약품 플랜에 관한 질문에 답변해 드릴 무료 통역 서비스를 제공합니다. 통역사를 이용하시려면 1-833-592-1093 로 전화해 주십시오. 한국어를 구사하는 직원이 도와드릴 수 있습니다. 통화는 무료입니다. 또한 큰 활자, 점자 또는 오디오와 같은 무료 보조 지원과 서비스도 제공합니다. 이러한 요청을 하시려면 위의 번호로 전화해 주십시오.

**Russian:** Мы можем предоставить вам бесплатные услуги переводчика, чтобы вы могли получить ответы на все ваши вопросы о нашем плане медицинского обслуживания и обеспечения лекарственными препаратами. Чтобы запросить услуги переводчика, просто позвоните по номеру 1-833-592-1093. Сотрудник, владеющий русским языком, сможет вам помочь. Звонок бесплатный. Мы также предлагаем бесплатные вспомогательные средства и услуги, например материалы, напечатанные крупным шрифтом, шрифтом Брайля или в виде

аудиозаписи. Просто позвоните нам по вышеуказанному номеру, чтобы сделать соответствующий запрос.

**Arabic:**
لدينا خدمات مترجم فوري مجانية للإجابة على أي أسئلة التي قد تكون لديك حول خطتنا للرعاية الصحية أو خطة الأدوية الخاصة بنا. للحصول على مترجم فوري، فقط اتصل بنا على الرقم 1-833-592-1093. يمكن لشخص يتكلم اللغة الإنجليزية أن يساعدك. إن المكالمة مجانية. نحن نقدم أيضًا مساعدات وخدمات مساعدة مجانية، مثل طباعة بأحرف كبيرة، أو بطريقة برايل، أو ملفات صوتية. فقط اتصل بنا على الرقم المذكور أعلاه لتقديم هذا الطلب.

**Hindi:** हमारे स्वास्थ्य या दवा योजना के बारे में आपके किसी भी प्रश्न का उत्तर देने के लिए हमारे पास निःशुल्क दुभाषिया सेवाएँ हैं। दुभाषिया पाने के लिए बस हमें 1-833-592-1093 पर कॉल करें। कोई हिन्दी बोलने वाला व्यक्ति आपकी मदद कर सकता है। कॉल निःशुल्क है। हम बड़े प्रिंट, ब्रेल या ऑडियो जैसी निःशुल्क सहायक सामग्री और सेवाएं भी प्रदान करते हैं। इस अनुरोध के लिए बस हमें ऊपर दिए गए नंबर पर कॉल करें।

**Italian:** Disponiamo di servizi gratuiti di interpretariato per rispondere a eventuali domande sul nostro piano sanitario o farmaceutico. Per chiedere un interprete basta chiamarci al numero 1-833-592-1093. La assisterà un operatore che parla italiano. La chiamata è gratuita. Forniamo inoltre servizi e supporti ausiliari gratuiti, come ad esempio stampa in caratteri grandi, braille o audio. Per questa richiesta basta chiamarci al numero sopra indicato.

**Portuguese:** Temos serviços de intérprete gratuitos para responder a quaisquer perguntas que possa ter sobre o nosso plano de saúde ou medicamentos. Para obter um intérprete, ligue para 1-833-592-1093. Alguém que fala português poderá prestar assistência. A chamada é gratuita. Também fornecemos recursos e serviços auxiliares gratuitos, como impressão em letras grandes, braile ou áudio. Basta ligar para o número acima e fazer tal solicitação.

**Haitian Creole:** Nou gen sèvis entèprèt gratis pou reponn nenpòt kesyon ou ka genyen sou plan sante oswa medikaman nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-833-592-1093. Yon moun ki pale kreyòl ka ede w. Apèl la gratis. Nou bay èd ak sèvis oksilyè gratis tou, tankou gwo lèt, bray oswa odyo. Jis rele nou nan nimewo ki anwo a pou fè demann sa a.

**Polish:** Oferujemy bezpłatne usługi tłumaczeniowe, aby odpowiedzieć na wszystkie Państwa pytania dotyczące planu ubezpieczenia zdrowotnego lub refundacji leków. Aby skorzystać z usług tłumacza, należy zadzwonić pod numer 1-833-592-1093. Osoba mówiąca po polsku udzieli Państwu pomocy. Połączenie jest bezpłatne. Zapewniamy również wsparcie i usługi pomocnicze, takie jak materiały pisane dużym drukiem, alfabetem Braille'a lub nagrania głosowe. Aby o nie poprosić, wystarczy zadzwonić pod podany powyżej numer telefonu.

**Khmer:** យើងមានសេវាកម្មអ្នកបកប្រែផ្តាល់មាត់ឥតគិតថ្លៃដើម្បីឆ្លើយសំណួរណាមួយ ដែលអ្នកអាចមានអំពីគម្រោងសុខភាព ឬគម្រោងឱសថរបស់អ្នក។ ដើម្បីទទួលបានអ្នកបកប្រែផ្តាល់មាត់ម្នាក់ សូមទូរស័ព្ទមកយើងតាមលេខ 1-833-592-1093។ នរណាម្នាក់ដែលនិយាយ ភាសាអង់គ្លេស អាចជួយអ្នកបាន។
ការទាក់ទងតាមទូរស័ព្ទនេះគឺពុំគិតថ្លៃទេ។ យើងក៏ផ្តល់ជំនួយបន្ថែម
និងសេវាកម្មជំនួយដោយឥតគិតថ្លៃផងដែរ ដូចជាអក្សរពុម្ពធំ អក្សរស្នាប ឬសំឡេង។
គ្រាន់តែទូរស័ព្ទមកយើងខ្ញុំតាមលេខខាងលើដើម្បីធ្វើការស្នើសុំនេះ។

**Greek:** Διαθέτουμε δωρεάν υπηρεσίες διερμηνείας για να απαντάμε σε οποιεσδήποτε ερωτήσεις μπορεί να έχετε σχετικά με το πρόγραμμα ιατρικής ή φαρμακευτικής περίθαλψης που παρέχουμε. Για να βρείτε διερμηνέα, απλώς καλέστε μας στον αριθμό 1-833-592-1093. Κάποιος που μιλά αγγλικά μπορεί να σας βοηθήσει. Η κλήση είναι χωρίς χρέωση. Επίσης, παρέχουμε δωρεάν βοηθήματα και βοηθητικές υπηρεσίες, όπως μεγάλη γραμματοσειρά, μπράιγ ή ηχητική μορφή. Απλώς καλέστε μας στον παραπάνω αριθμό για να υποβάλετε αυτό το αίτημα.

**Gujarati:** અમારી આરોગ્ય અથવા દવા યોજના વિશે તમને હોય શકે તેવા કોઈપણ પ્રશ્નોના જવાબ આપવા માટે અમારી પાસે મફત દુભાષિયા સેવા છે. દુભાષિયા સેવા મેળવવા માટે, અમને 1-833-592-1093 પર કૉલ કરો. ગુજરાતી બોલતી વ્યક્તિ તમને મદદ કરી શકે છે. કૉલ મફત છે. અમે મોટા પ્રિન્ટ, બ્રેઇલ અથવા ઑડિઓ જેવી મફત વધારાની સહાય અને સેવાઓ પણ પ્રદાન કરીએ છીએ. આ વિનંતી કરવા માટે અમને ફક્ત ઉપરના નંબર પર કૉલ કરો.