

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES  
**APPOINTMENT OF REPRESENTATIVE**



**FORM APPROVED**  
OMB no. 0938-0950

NAME OF BENEFICIARY	Passport Advantage HMO ID #
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**SECTION I: APPOINTMENT OF REPRESENTATIVE**

**To be completed by the beneficiary:**

I appoint this individual: \_\_\_\_\_ to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request, to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

Signature of Beneficiary		Date
Street Address		Phone Number ( <small>AREA CODE</small> ) -
City	State	Zip

**SECTION II: ACCEPTANCE OF APPOINTMENT**

**To be completed by the representative:**

I, \_\_\_\_\_, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the beneficiary's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a/an \_\_\_\_\_

**(PROFESSIONAL STATUS OR RELATIONSHIP TO THE PARTY, E.G. ATTORNEY, RELATIVE, ETC.)**

Signature		Date
Street Address		Phone Number ( <small>AREA CODE</small> ) -
City	State	Zip

**SECTION III: WAIVER OF FEE FOR REPRESENTATION**

**Instructions: This form should be filled out if the representative waives a fee for such representation.**

(Note that providers or suppliers may not charge a fee for representation and thus, all providers or suppliers that furnished the items or services at issue must complete this section.)

I waive my right to charge and collect a fee for representing \_\_\_\_\_ before the Secretary of the Department of Health and Human Services.

Signature	Date
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**SECTION IV: WAIVER OF PAYMENT FOR ITEMS OR SERVICES AT ISSUE**

**Instructions: Providers or suppliers that furnished the items or services at issue must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act.** (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, and could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for furnished items or services at issue involving 1879(a)(2) of the Act.

Signature	Date
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