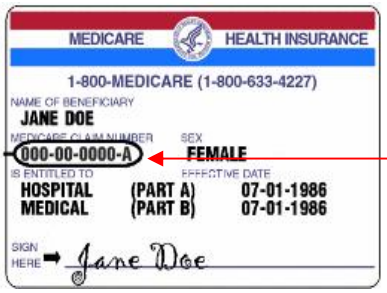
Instructions for Completing Appointment of Representative Form


MEDICARE HEALTH INSURANCE
1-800-MEDICARE (1-800-633-4227)
NAME OF BENEFICIARY
JANE DOE
MEDICARE CLAIM NUMBER
000-00-0000-A
SEX
FEMALE
IS ENTITLED TO
EFFECTIVE DATE
HOSPITAL (PART A) 07-01-1986
MEDICAL (PART B) 07-01-1986
SIGN HERE
Jane Doe

Section I: Appointment of Representative

1. **Name of Party**: Print name of the Medicare beneficiary
2. **Medicare or National Provider Identifier Number**: The number that appears on the beneficiary's Medicare card
3. **Appointed Individual**: Print name of the person being appointed as the representative
4. **Signature of Party Seeking Representation and Date**: Beneficiary ***must*** sign full name *and* date the form
5. **Address and phone number:** Complete beneficiary's address *and* phone number

APPOINTMENT OF REPRESENTATIVE

(1) NAME OF PARTY	MEDICARE OR NATIONAL PROVIDER IDENTIFIER NUMBER
Jane Doe	000-00-0000A (2)

SECTION I: APPOINTMENT OF REPRESENTATIVE

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint this individual: (3) Dr. Mark Henry 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.

(4) SIGNATURE OF PARTY SEEKING REPRESENTATION		DATE
Jane Doe		2/11/11 (4)
(5) STREET ADDRESS: 10 Test Drive (5)		PHONE NUMBER (*with* Area Code): 555-321-5678
CITY: Rutherford	STATE: New Jersey	ZIP: 07070

Section II: Acceptance of Appointment

6. **Print representative's name to accept appointment**
7. **Print relationship of representative to beneficiary**
8. **Signature and Date:** Representative ***must*** sign full name (not initials) *and* date to accept appointment
9. **Address and phone number:** Complete representative's address *and* phone number

SECTION II: ACCEPTANCE OF APPOINTMENT

To be completed by the representative:

(6) I Mark Henry, MD 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 party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an Beneficiary's Physician (7)
(PROFESSIONAL STATUS OR RELATIONSHIP TO THE PARTY, E.G. ATTORNEY, RELATIVE, ETC.).

(8) SIGNATURE		DATE
Mark Henry, M.D		2.11.11 (8)
(9) STREET ADDRESS: 123 Main Street (9)		PHONE NUMBER (*with* Area Code): 555-321-5999
CITY: Rutherford	STATE: New Jersey	ZIP: 07072

- ***ALL*** fields must be completed in Sections I and II. Sections III and IV are not required for Part D Appeals.
- Where a signature is required, please sign the full name, not initials.
- Please include any representation documentation you may already have when returning this form.

If you need assistance completing this form, call **1-877-456-5302**.

Form Approved
OMB No. 0938-0950

Appointment of Representative

Name of Party	Medicare or National Provider Identifier Number

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier:
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 Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code

Section 2: 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 of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **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

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as representative for a beneficiary to whom they provided 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

Charging of Fees for Representing Beneficiaries Before the Secretary of the Department of Health and Human Services

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Department of Health and Human Services (DHHS) (i.e., an Administrative Law Judge (ALJ) Hearing, Medicare Appeals Council review, or a proceeding before an ALJ or the Medicare Appeals Council as a result of a remand from the federal district court) is required to obtain approval of the fee in accordance with 42 CFR §405.910(f).

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing or request for Medicare Appeals Council review. Approval of a representative's fee 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 a legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation.

Authorization of Fee

The requirement for the approval of fees ensures that representative will receive fair value for the services performed before DHHS on behalf of a claimant while at the same time giving a measure of security that the fees are determined to be reasonable. In approving a requested fee, the ALJ 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 in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

Conflict of Interest

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.

Where to Send This Form

Send this form to the same location where you are sending (or have already sent): (1) your appeal if you are filing an appeal, (2) grievance if you are filing a grievance, or (3) initial determination or decision if you are requesting an initial determination or decision.

If additional help is needed, contact your Medicare plan or 1-800-MEDICARE (1-800-633-4227).
