

## 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) ( <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> ) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
City	State <input type="text"/> <input type="text"/>	ZIP code <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Email (optional)	Fax (optional) ( <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> ) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Signature	Date signed (mm/dd/yyyy) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

### 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) ( <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> ) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
City	State <input type="text"/> <input type="text"/>	ZIP code <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Email (optional)	Fax (optional) ( <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> ) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Signature	Date signed (mm/dd/yyyy) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

**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) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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### 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) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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## Instructions and Regulation Requirements

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### 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](https://www.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.

### 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](https://www.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.

### Where to send this form

Send this form to the same location you send your claim, appeal, grievance, or request.

### 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](https://www.medicare.gov/about-us/accessibility-nondiscrimination-notice), or call 1-800-MEDICARE for more information.

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**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.

## ***Discrimination is Against the Law***

The Health Plan of West Virginia (The Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, creed, ancestry, religion, national origin, age, disability, marital status, health status, income level, or sex (consistent with the scope of sex discrimination as described by applicable law).

The Health Plan does not exclude people or treat them less favorably because of race, color, creed, ancestry, religion, national origin, age, disability, marital status, health status, income level, or sex.

The Health Plan:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Director, Health Equity & Wellness.

If you believe that The Health Plan of West Virginia has failed to provide these services or discriminated in another way on the basis of race, color, creed, ancestry, religion, national origin, age, disability, marital status, health status, income level, or sex, you can file a grievance with: Director, Health Equity & Wellness, 1110 Main Street, Wheeling, West Virginia 26003, Phone: 740.699.6142, TTY: 711, Fax: 740.699.6163, [civilrightscoordinator@healthplan.org](mailto:civilrightscoordinator@healthplan.org). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Director, Health Equity & Wellness is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1.800.368.1019, 1.800.537.7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

This notice is available at The Health Plan's website: [healthplan.org](http://healthplan.org).



1110 Main Street, Wheeling, WV 26003-2704 | [healthplan.org](http://healthplan.org)

### **English**

**ATTENTION:** If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1.877.847.7907 (TTY: 711) or speak to your provider.

### **Spanish**

Español

**ATENCIÓN:** Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1.877.847.7907 (TTY: 711) o hable con su proveedor.

### **Chinese (Simplified)**

中文 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1.877.847.7907 (TTY: 711) 或咨询您的服务提供者。

### **Chinese (Traditional)**

中文

注意：如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1.877.847.7907 (TTY: 711) 或與您的提供者討論。

### **German**

Deutsch

**ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1.877.847.7907 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

### **Arabic**

العربية

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1.877.847.7907 (TTY: 711) أو تحدث إلى مقدم الخدمة.

## Pennsylvania Dutch

Hinweis: Wenn du Pennsylvania Deitsch redst, kannst du kostenlose Sprachhilfe-Dienste nutzen. Auwersichtliche Hilfsmittel und Dienste, um Information in zugängliche Formate zu geben, sind auch kostenlos verfügbar. Ruf 1.877.847.7907 (TTY: 711) an oder red mit deinem Anbieter für Hilfe.

## Russian

РУССКИЙ

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1.877.847.7907 (TTY: 711) или обратитесь к своему поставщику услуг.

## French

Français

ATTENTION: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1.877.847.7907 (TTY: 711) ou parlez à votre fournisseur.

## Vietnamese

Việt

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1.877.847.7907 (TTY: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

## Korean

한국어

주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1.877.847.7907 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

## Cushite (Oromo)

HUBACHIISA: Afaan Oromoo dubbattu yoo ta'eef, tajaajilli gargaarsa Afaan Hiikuu (Turjumaanaa) bilisaan kan isiniif dhiyaatu ta'a. Gargaarsi walqabataa fi tajaajilli sirrii ta'ee fi odeeffannoo bifa unkaalee dhaqqabamoo ta'aaniin kennuunis bilisaan ni argama. 1.877.847.7907 (TTY: 711) irratti bilbilaa ykn dhiyeessaa keessan waliin haasa'aa.

## Japanese

日本語

注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1.877.847.7907 (TTY: 711) までお電話ください。または、ご利用の事業者にご相談ください。

## Italian

Italiano

ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama 1.877.847.7907 (TTY: 711) o parla con il tuo fornitore.

## Dutch

Nederlands

LET OP: als je Nederlands spreekt, zijn er gratis taalhelpdiensten voor je beschikbaar. Passende hulpmiddelen en diensten om informatie in toegankelijke formaten te verstrekken, zijn ook gratis beschikbaar. Bel 1.877.847.7907 (TTY: 711) of spreek met je provider.

## Ukrainian

українська мова

УВАГА: Якщо ви розмовляєте українською мовою, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1.877.847.7907 (TTY: 711) або зверніться до свого постачальника.

## Romanian

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii gratuite de asistență lingvistică. De asemenea, sunt disponibile gratuit ajutoare și servicii auxiliare adecvate pentru a furniza informații în formate accesibile. Sunați la 1.877.847.7907 (TTY: 711) sau vorbiți cu furnizorul dvs.

## Tagalog

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1.877.847.7907 (TTY: 711) o makipag-usap sa iyong provider.