aetna Authorized Representative Request

[FAX Number

Member Name	IAetna ID Number
Provider of Service: Bruno Brown Plastic Surgery;	
Name and Dates of Service or Proposed Service	

I, _____ do hereby name
Print the name of the member who is receiving the service or supply

Bruno Brown Plastic Surgery; Howard Healthcare Group and/or their attorneys.

Print the name of the person who is being authorized to act on the member's behalf

to act as my authorized representative in requesting *(check one)* ___ a complaint or ___ an appeal from Aetna regarding the above-noted service or proposed service.

IMPORTANT: Your signature below means that you understand and agree to the following:

- In conjunction with this *(check one)* complaint or appeal, Aetna may disclose Protected Health Information ("PHI") to the above-named authorized representative ("Representative").
- **The PHI disclosed pursuant to this authorization may include diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases, sexually-transmitted diseases, HIV/AIDS, and/or genetic marker information.**
- Information disclosed pursuant to this authorization may be redisclosed by the Representative and may no longer be protected by federal or state privacy regulations.
- If you would like to pursue *(check one)* a complaint or an appeal, at the Representative's request, but do **not** want the Representative to receive any PHI or other information related to the *(check one)* ___ complaint or ___ appeal, including the *(check one)* ___complaint or __ appeal, decision, you may indicate that choice by checking the box on the signature line below.
- Your ability to enroll in an Aetna plan, and your eligibility for benefits and payment for services, will not be affected if you do not sign this form. However, without your signature, we cannot process the *(check one)* ___complaint or __ appeal, initiated by the Representative.
- This authorization is only valid for the duration of the *(check one)* ___complaint or ___appeal. If you sign this form, you may revoke the authorization at any time by notifying Aetna in writing at the address above. Revoking this authorization will not have any effect on actions that Aetna took in reliance on the authorization before we received the notification.

___ Please accept this *(check one)* ___complaint or ___ appeal, from my representative on my behalf; however, forward all information related to this *(check one)* ___complaint or ___appeal, including the *(check one)* ___ complaint or ___appeal decision and any request you may have for additional information, to my attention only.

Signature	IDate
Print Name	
If person signing this Authorization is not the Member, describe relationship to the Member (i.e. Parent, Legal Representative)	

Legal Representatives signing this authorization on behalf of a Member must furnish a copy of a health care power of attorney, or other relevant document that grants the applicable legal authority.