DEPARTMENT:	Utilization Management
SUBJECT:	Appointment of Representatives
PRODUCT LINE:	DSNP
POLICY NUMBER:	UM128
ORIGINAL POLICY EFFECTIVE DATE:	3/10/2024
LAST REVISED DATE:	N/A
LAST REVIEWED DATE:	3/8/2025

SCOPE:

It is important for Medicare members to be able to appoint a representative because it allows them to have someone help with Medicare-related matters, such as: obtaining prior authorization, understanding benefits, handling claims and payments, appealing coverage decisions, and requesting exceptions or grievances.

POLICY:

This policy outlines the processes related to representatives, requirements for appointment of representatives, and representatives filing on behalf of enrollees**.** Individuals who represent enrollees may either be appointed or authorized to act on behalf of the enrollee in filing a grievance, requesting an initial determination, or in dealing with any of the levels of the appeals process.

PROCEDURE:

Representatives Filing on Behalf of Enrollees

Who Can Act or be Appointed as a Representative	Requirement for Representation
Any individual appointed by the enrollee (e.g., relative, friend, advocate, attorney)	The enrollee must submit Form CMS-1696, Appointment of Representative (AOR) or an equivalent written notice (hereinafter, collectively referred to as a representative form).
An individual authorized under state or other applicable law. Could include, but is not limited to: • Court appointed guardian • Individual with durable power of attorney • A health care proxy • A person designated under a health care consent statute • Executor of an estate	• A representative form is not required. • Authorized individual must produce appropriate legal papers supporting his or her status under state or other applicable law.

When verbally submitting grievances, initial determinations, and reconsiderations, when applicable, enrollees cannot verbally appoint a representative and must submit a valid representative form. However, if a purported representative makes a verbal request and the enrollee verbally confirms they want to file the request described by the purported representative, the request must be documented and processed as a request from the enrollee, not a representative. All communication (written and verbal) must be delivered to the enrollee until a valid, written representative form is on file. In these instances, plans are not required to make efforts to obtain a written representative form.

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Appointment of Representative (AOR) Form or Equivalent Written Notice

If an appointment is made using the OMB-approved Form CMS-1696, Appointment of Representative (AOR), or an equivalent written notice (see requirements below) GHC will accept it. Plans are prohibited from requiring the use of a specific form for appointments. The AOR contains the necessary elements to meet representation requirements and is preferred. (Note: Section 4 of the AOR does not apply to MA plans or Part D plan sponsors.) GHC does not require information beyond what is included in the AOR or the requirements outlined below for an equivalent written notice.

GHC will accept an AOR with electronic signatures if the form is submitted through the plan's secure portal or other secure electronic means (e.g., a secure messaging system), provided all applicable regulatory and CMS website/electronic communication requirements are met. AORs containing an enrollee's HICN (Health Insurance Claim Number), Medicare Beneficiary Identifier (MBI) or plan ID number and are treated as protected information.

Requirements of An Equivalent Written Notice

An equivalent written notice requires the following:

- Name, address, and telephone numbers of the enrollee and the individual being appointed
- Enrollee's HICN or Medicare Beneficiary Identifier, or plan ID number
- The appointed representative's professional status or relationship to the party
- A written explanation of the purpose and scope of the representation
- A statement that the enrollee is authorizing the representative to act on his or her behalf for the claim(s) at issue, and a statement authorizing disclosure of individually identifying information to the representative
- A statement by the individual being appointed that he or she accepts the appointment
- Is signed and dated by the enrollee and the individual being appointed

Representative Form Validity

A representative form is valid for one year from the date it has signatures for both the enrollee and the appointee, unless revoked. (For example, if the enrollee signs the form on January 1, 2019 and the representative signs on January 3, 2019 (or vice versa), the form is effective for one year starting on January 3, 2019.)

If the enrollee would like the same individual to continue serving as a representative after one year, the enrollee must reappoint that person by submitting a new representative form. A form is valid for the life of a grievance, coverage request, or appeal if the grievance, coverage request, or appeal was received within one year of the date a representative form is signed by both the enrollee and appointee.

Maintaining the Representative Form

The representative form is maintained and accessible in our electronic care management system, therefore, a photocopy of the signed representative form is not required to be filed with future grievances, coverage requests, or appeals made on behalf of the enrollee to continue representation. A copy of the representative form on file for requests will be sent with the case file to higher level adjudicators, if applicable.

Note: A representative form submitted with a request that specifically limits the appointment to MA or Part D benefits is not valid for requests that involve Part D or MA benefits, respectively. In these instances, the enrollee must properly execute separate representative forms.

Missing or Defective Representative Form

When a request for a grievance, initial determination, or level 1 appeal is filed by a person claiming to be a representative, but the party does not provide the valid representative documentation to show that the individual is authorized to act on the enrollee's behalf, GHC will:

- For expedited requests, develop procedures to ensure that expedited requests are not inappropriately delayed
- Inform the enrollee and purported representative, in writing, that the grievance, coverage request, or appeal is not valid until documentation is provided
- Make and document its reasonable efforts to secure the necessary representative Documentation

GHC will not issue a decision until or unless such documentation is obtained. The plan is not required to undertake a review until or unless such documentation is obtained, but may choose to begin the review while continuing efforts to obtain the representative documentation.

The timeframe for acting on a grievance, coverage request, or appeal begins when the representative documentation is received. If the plan does not receive representative documentation by the conclusion of the applicable timeframe, plus any applicable extension, the following apply:

Dismissal of coverage and appeal requests: The request is dismissed because the person or entity making the request is not permitted to request a coverage decision or appeal or is not a proper party. The plan must mail or otherwise transmit a written dismissal notice to the enrollee (or other proper party) and should also send the notice to the person asserting representative status. The dismissal notice must state all the following:

1. the reason for the dismissal
2. the right to request that the plan vacate the dismissal action
3. the right to request review of the dismissal.
4. The notice should also explain how the invalid request can be cured and that the request will be processed if the enrollee or representative submits a properly executed form. See 42 CFR §§ 422.568(g) and (h), 422.582(f) and (g), 423.568(i) and (j), 423.582(e) and (f). See §50.9 for additional information regarding reconsideration dismissal procedures.

Grievances: GHC is not required to and will not process grievances when the person or entity making the grievance is not permitted by 42 CFR §§ 422.564 or 423.564. In circumstances where necessary representative documentation is missing, and not received by the end of the grievance processing period, GHC will notify the enrollee and the purported representative that the plan is unable to process the grievance. This notice will include instructions on how the enrollee, or a valid representative, may resubmit the grievance.

Authority of a Representative

The representative has all the rights and responsibilities of an enrollee in filing a grievance, obtaining a coverage request, or in dealing with any levels of the appeals process. If an enrollee has identified a representative, all notices or other correspondence that must be sent to the enrollee per the regulations at 42 CFR Part 422 or 423 Subpart M must be sent to the enrollee's representative instead of to the enrollee. Plans may send notices or correspondence to both the representative and enrollee but are not required.

Reference Sources:

APPROVED: Michele Bauer MD. DATE: 3/8/2025

Formal policies and procedures require department manager review, approval, and signature. Executive and/or administrative policies and procedures require CEO/General Manager review, approval, and signature.

REVISION HISTORY:

Rev. Date	Revised By/Title	Summary of Revision
3/8/2025	Michele Bauer, MD, CMO	Reviewed. No changes.