

Appointment of Representative (AOR) Form

Do you want to name someone you trust to act on your behalf to ask for an exception or appeal, request coverage, or make a complaint with Healthfirst?

You will both need to complete and sign this form and return it by mail or fax. If you'd like help, call the Member Services phone number on your Healthfirst Member ID card.

Please be sure to complete all fields on both sides, and have both parties sign where indicated, so we can process your form.

Section 1 Member Information and Signature									
To be completed by the Healthfirst Member seeking representation.									
Member ID									
First Name	Middle Initial		Last Name						
Mailing Address (Include Apt., Bldg.)									
City	State		Zip Code						
Phone Number Email (Opt			ptional)						
I appoint the individual named in Section 2 to act as my representative in connection with my claim or asserted right under the Social Security 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 claim, appeal, grievance or request. I understand that personal medical information related to my request may be disclosed to the representative indicated in Section 2.									
Signature of Member				Date (MM/DD/YYYY)	SIGN	I HERE			

Complete on Reverse Side ▶

Section 2 Representative Information and Signature									
To be completed by the representative.									
First Name	Middle Initial		Last Name						
Mailing Address (Include Apt., Bldg.)									
City	State		Zip Code						
Phone Number	Email (Optional)								
Professional status or relationship to Member (for example, attorney, relative, etc.)									
I hereby accept this appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS); 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 I receive may be subject to review and approval by the Secretary.									
Signature of Legal Representative				Date (MM/DD/YYYY)	SIGN HER				

Return this signed, completed form by mail, email, or fax:

For appeals, grievances, and requests for coverage related to medical issues:

Appeals and Grievances Department Healthfirst P.O. Box 5166 New York, NY 10274-5166

Email: AORforms@healthfirst.org

Fax: 1-646-313-4618

For appeals, grievances, and requests for coverage related to prescription issues:

CVS Caremark Part D Services P.O. Box 52000, MC109 Phoenix, AZ 85072-2000 Fax: 1-855-633-7673