

# MEDICA®

## Appointment of Representative

### 1. Member Information

Member Name: \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Mailing Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

**Member ID # (required):** \_\_\_\_\_

### 2. Appointment of Representative

I hereby appoint the individual named below to act as my representative for the purpose indicated in this form. I understand that this individual will be my agent and is authorized to act on my behalf as I have indicated below:

\_\_\_\_\_ I hereby appoint the individual named below to act as my representative **for all purposes** related to my membership in my health benefit plan.

**OR**

\_\_\_\_\_ I hereby appoint the individual named below to act as my representative **for the following activity:**

\_\_\_\_\_  
\_\_\_\_\_.

Representative Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Relationship: \_\_\_\_\_

### 3. Personal Information

I understand that my personal medical information related to this appointment may be disclosed to the representative indicated below. Once released, I understand that such information may no longer be protected by privacy laws and may be further disclosed by my representative without my authorization.

#### 4. Revocation

I understand that this appointment will remain in effect until I revoke it. I may revoke this appointment at any time by providing written notice to the address below. However, I understand that my revocation will not affect any action taken, or any information already released, based upon this appointment before my request to revoke has been received.

#### 5. Member Signature

I have fully read this form and hereby appoint the individual indicated above to act as my representative, subject to the terms and conditions of this form. I understand that my treatment, payment, enrollment, or eligibility for benefits is not affected by whether or not I sign this form.

**Signature of Member\*:** \_\_\_\_\_

**Date:** \_\_\_\_\_

\*If someone other than the member is signing this form on behalf of the member, please provide the name of such person, the relationship to the member, and a copy of legal authorization (e.g. power of attorney, legal guardian, foster parent).

Name of Person Signing for Member: \_\_\_\_\_

Relationship to Member: \_\_\_\_\_

**NOTE TO MEDICA MEDICARE MEMBERS:** You must complete a CMS Appointment of Representative (CMS-1696) form in order to designate a representative to act on your behalf to: (a) file a grievance; (b) request a coverage termination or exception; (c) request an organization determination; or (d) request an appeal.

**Return completed form to:  
Medica PO Box 6100, Eau Claire, WI 54702-9863**

Medica is a Cost, HMO-POS, HMO, HMO I-SNP and PPO plan with a Medicare contract. Enrollment in Medica depends on contract renewal.

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# Discrimination is Against the Law

Medica complies with applicable Federal civil rights laws and will not discriminate against any person based on his or her race, color, creed, religion, national origin, sex, gender, gender identity, health status including mental and physical medical conditions, marital status, familial status, status with regard to public assistance, disability, sexual orientation, age, political beliefs, membership or activity in a local commission, or any other classification protected by law. Medica:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: TTYcommunication
- Written information in other formats (large print, audio, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters and information written in other languages

If you need these services, contact the number on the back of your identification card. If you believe that Medica has failed to provide these services or discriminated in another way on the basis of your race, color, creed, religion, national origin, sex, gender, gender identity, health status including mental and physical medical conditions, marital status, familial status, status with regard to public assistance, disability, sexual orientation, age, political beliefs, membership or activity in a local commission, or any other classification protected by law, you can file a grievance with: Civil Rights Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422, TTY: 711, [civilrightscoordinator@medica.com](mailto:civilrightscoordinator@medica.com).

You can file a grievance in person or by mail, fax, or email. You may also contact the Civil Rights Coordinator if you need assistance with filing a complaint. 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 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**If you want free help translating this information, call the number included in this document or on the back of your Medica ID card.**

Si desea asistencia gratuita para traducir esta información, llame al número que figura en este documento o en la parte posterior de su tarjeta de identificación de Medica.

Yog koj xav tau kev pab dawb kom txhais daim  
ntawv no, hu rau tus xov tooj nyob hauv daim ntawv  
no los yog nyob nraum qab ntawm koj daim npav  
Medica ID.

如果您需要免費翻譯此資訊，請致電本文檔中或者在您的Medica ID卡背面包含的號碼。

Nếu quý vị muốn trợ giúp dịch thông tin này miễn phí, hãy gọi vào số có trong tài liệu này hoặc ở mặt sau thẻ ID Medica của quý vị.

Odeeffannoo kana gargaarsa tolaan akka isinii hiikamu yoo barbaaddan, lakkoobsa barruu kana keessatti argamu ykn ka dugda kaardii Waraqaa Eenvummaa Medica irra jiruun bilbila'a.

إذا كنت تريد مساعدة مجانية في ترجمة هذه المعلومات،  
فأتصل على الرقم الوارد في هذه الوثيقة أو على ظهر  
بطاقة تعريف مديك الخاصة بك.

Если Вы хотите получить бесплатную помощь в переводе этой информации, позвоните по номеру телефона, указанному в данном документе и на обратной стороне Вашей идентификационной карты Medica.

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປຂໍ້ມູນນີ້ຟຣີ, ໃຫ້  
ໂທຫາເລກໜາຍທີມີຢູ່ໃນເອກະສານນີ້ ຫຼື ຢູ່ດ້ານຫຼັງຂອງບັດ  
Medica ຂອງທ່ານ.

이 정보를 번역하는 데 무료로 도움을 받고 싶으시면,  
이 문서에 포함된 전화번호나 Medica ID 카드 뒷면의  
전화번호로 전화하십시오.

Si vous voulez une assistance gratuite pour traduire ces informations, appelez le numéro indiqué dans ce document ou au dos de votre carte d'identification Medica.

နမူအဲဒီးတၢ်ကျိးထံစၢကလိန့ၢ်နၢတၢ်ဂ့ၢ်တၢ်ကျိးအံၤလၢအကလိန့ၢ်  
 ,ကိးလိတဲစီနီၣ်ဂံၢ်လၢအပၣ်ယုၣ်လၢလံာ်တိလံာ်မိအပူၤအံၤမ့တမ့ၢ်ဖဲန  
 န့ၣ်ခဝေလံာ်အၣ်သးခးကအလိၣ်ခံတကပၤအဖီခိၣ်န့ၣ်တက့ၢ်.

Kung nais mo ng libreng tulong sa pagsasalin ng impormasyong ito, tawagan ang numero na kasama sa dokumentong ito o sa likod ng iyong Kard ng Medica

ይህን መረጃ ለመተርጎም ነጻ እርዳታ የሚፈልጉ ከሆነ በዝህ ሰነድ ውስጥ ያለውን ቁጥር ወይም Medica መታወቂያ ካርድዎ በስተጀርባ ያለውን ይደውሉ።

Ako želite besplatnu pomoć za prijevod ovih informacija, nazovite broj naveden u ovom dokumentu ili na poledini svoje ID kartice Medica.

Díí t'áá jíík'e shá ata' hodoonih nínízingo éi ninaaltsoos  
Medicaa bee nésho' díłzinígí bine'dée' námbuu biki' ágíjii'  
béesh bee hodíłnihi.

Wenn Sie bei der Übersetzung dieser Informationen kostenlose Hilfe in Anspruch nehmen möchten, rufen Sie bitte die in diesem Dokument oder auf der Rückseite Ihrer Medica-ID-Karte angegebene Nummer an.