



**APPOINTMENT OF REPRESENTATIVE AND AUTHORIZATION TO DISCLOSE INFORMATION**

**I APPOINT** \_\_\_\_\_

**NAME AND ADDRESS OF A REPRESENTATIVE**

**TO ACT AS MY REPRESENTATIVE IN CONNECTION WITH MY APPEAL UNDER 32CFR199.10, APPEAL AND HEARING PROCEDURES. IN ADDITION, AUTHORIZE THE TRICARE MANAGEMENT ACTIVITY (TMA) TO RELEASE TO SAID REPRESENTATIVE, INFORMATION RELATED TO MEDICAL TREATMENT, AND IF NECESSARY, PHOTOCOPIES OF ANY MEDICAL RECORDS WHICH MAY BE REQUIRED FOR ADJUDICATION OF MY CLAIM FOR TRICARE BENEFITS TO AVOID THE POSSIBILITY OF A CONFLICT OF INTEREST, AN OFFICER OR EMPLOYEE OF THE UNITED STATES SUCH AS AN EMPLOYEE OR MEMBER OF A UNIFORMED SERVICE, INCLUDING AN EMPLOYEE OR STAFF MEMBER OF A UNIFORMED SERVICE LEGAL AN MTF PROVIDER, OR A HEALTH BENEFITS ADVISOR, IS NOT ELIGIBLE TO SERVE AS A REPRESENTATIVE. AN EXCEPTION USUALLY IS MADE WHEN AN EMPLOYEE OR MEMBER OF A UNIFORMED SERVICE IS REPRESENTING AN IMMEDIATE FAMILY MEMBER.**

**IN ADDITION, I AUTHORIZE THE TRICARE MANAGEMENT ACTIVITY (TMA) TO RELEASE TO SAID REPRESENTATIVE, INFORMATION RELATED TO MEDICAL TREATMENT, AND IF NECESSARY, PHOTOCOPIES OF ANY MEDICAL RECORDS WHICH MAY BE REQUIRED FOR ADJUDICATION OF MY CLAIM FOR TRICARE BENEFITS.**

**I UNDERSTAND THE REPRESENTATIVE SHALL HAVE THE SAME AUTHORITY AS THE PARTY TO THE APPEAL AND NOTICE GIVEN TO THE REPRESENTATIVE SHALL CONSTITUTE NOTICE TO THE PARTY.**

**THIS CONSENT WILL EXPIRE UPON THE ISSUANCE OF THE FINAL AGENCY DECISION REGARDING MY APPEAL HOWEVER I RESERVE THE RIGHT TO WITHDRAW THIS AUTHORIZATION AT ANYTIME.**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**SIGNATURE OF BENEFICIARY OR GUARDIAN**

\_\_\_\_\_  
**PLEASE PRINT NAME**

\_\_\_\_\_  
**CASE IDENTIFICATION NUMBER**

**INSTRUCTIONS FOR COMPLETING THIS FORM:**

**1. YOU MUST INSERT THE NAME OF THE PERSON [YOUR SPOUSE OR LEGAL GUARDIAN, YOUR PHYSICIAN OR THE FACILITY (HOSPITAL, AMBULATORY SURGERY CENTER. RADIOLOGY CENTER)] YOU ARE APPOINTING AS YOUR REPRESENTATIVE TO ACT IN YOUR BEHALF OF THE APPEAL. THIS PERSON'S OR FACILITY'S NAME GOES ON THE TOP LINE.**

**2 PLEASE SIGN AND DATE AND HAVE THE APPOINTED PERSON OR FACILITY RETURN THIS FORM ALONG WITH THE WRITTEN REQUEST FOR AN APPEAL.**

For claims issue, mail this form to:

TRICARE South Region  
Claims Appeals  
P.O. Box 202002  
Florence, SC 29502-2002

For a referral or authorization issue, mail this form to:

Humana Military Healthcare Services  
Second Level Review/Clinical Appeals  
P.O. Box 740044  
Louisville, KY 40201-9973