DELTA DENTAL®

Authorized Representative Form for Appeals

Claim #:		Date of Service:	

Your Information	
Patient Name:	
Address:	
Telephone # and/or E-mail:	

Authorization to Release Health Information for Appeals

- I authorize Delta Dental of Massachusetts to disclose to the representative designated below, information relevant to my appeal including, but not limited to, medical records, claims and coverage information. I understand that this authorization is voluntary and Delta Dental of Massachusetts will not condition benefit payments, enrollment, or eligibility for benefits upon the execution of this form.
- I understand that I may revoke this authorization at any time by sending a written statement to the mailing address at the bottom of this form. I further understand that if I revoke my authorization, it will not affect any actions already taken by Delta Dental of Massachusetts based on this authorization.
- I understand that once Delta Dental of Massachusetts has disclosed health information, the recipient may re-disclose it in some situations. If the Authorized Representative named above is not a health care provider or another entity subject to federal or applicable state privacy laws, my personal health information may no longer be protected by those privacy laws and my Authorized Represented may further disclose my personal health information without my consent.
- I understand that I have the right to limit the information that Delta Dental of Massachusetts may release under this authorization. Any such limitations must be made in writing and sent to the address listed below.
- This authorization will automatically expire upon completion of the Appeal filed.

Authorized Representative Information	
Name:	
Address:	
Relationship to Subscriber/Patient:	
Telephone # and/or E-mail:	

Signature

I have read this Authorized Representative Form. I understand that, by signing this form, I am confirming my authorization that Delta Dental of Massachusetts may use and/or disclose my personal health information to the person(s) named.

Patient Signature:		Date:	

Contact Information

Keep a copy for your records and submit the original to us by email at appealsandgrievances@deltadentalmass.com, or by mail at: 465 Medford Suite, Ste 400, Boston, MA 02129-1454.