



## Appointment of Representative for Appeal and Authorization to Disclose Information Form Instructions

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As the managed care support contractor for the TRICARE West Region, TriWest Healthcare Alliance will have to determine if certain requested health care is either medically necessary or follows TRICARE policy before the care is authorized. If this pre-authorization is not granted and you cannot access the requested care, you—the TRICARE beneficiary—have the right to appeal that decision or appoint someone as a representative who may appeal on your behalf.

An appeal (or reconsideration) of a pre-authorization denial must be made in writing and submitted to TriWest's Reconsideration Department:

- Within 90 days of the initial denial determination for non-expedited appeals
- Within three days of receiving the initial denial determination for an expedited appeal (only when there is a denial of medical necessity)

Your denial decision letter will have more information on your options and will explain how to file an expedited appeal.

If you wish to appoint an individual to be your representative during the appeals process the attached form must be completed and submitted along with the written request for appeal.

You can find more information on the appeals process in the Beneficiary Services section of [www.triwest.com](http://www.triwest.com).

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*Further disclosure of information by the appointed representative may only be made in accordance with the provisions of the Privacy Act of 1974 and other applicable Federal law.*

Note: HIPAA authorization requirements do not apply to protected information used for treatment, payment, or health care operations including medical records requested for the provision of health care services. Privacy Act Statement – This information is protected under the Privacy Act of 1974 and shall be handled as “for official use only.” Violations of this may be punishable by fines, imprisonment, or both.



## Appointment of Representative for Appeal and Authorization to Disclose Information

I, \_\_\_\_\_, appoint  
(Print or Type Name of Person giving Consent)

\_\_\_\_\_  
(Print or Type Name and Address of Representative)

to act as my representative in connection with my appeal under 32 CFR 199.10, Appeal and Hearing Procedures. To avoid the possibility of a conflict of interest, I understand that an officer or employee of the United States, to include an employee or member of a Uniformed Service, an employee of a Uniformed Service legal office, an MTF Provider or a Health Benefits Advisor, is not eligible to serve as a representative. An exception to this is made when an employee of the United States or member of a Uniformed Service is representing an immediate family member.

I authorize the TRICARE Management Activity (TMA) to release to said representative, information related to my medical treatment, and if necessary, photocopies of any medical records which may be required for adjudication of my claim for TRICARE benefits.

I understand that 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 any time.

\_\_\_\_\_  
(Signature of Person Giving Consent)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Sponsor ID)

Please mail this completed form to:  
**TriWest Healthcare Alliance**  
**ATTN: RECONSIDERATION DEPARTMENT**  
**PO Box 86508**  
**Phoenix, Arizona 85080**  
**Or fax to: 1-866-312-5834**

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