Spring Health
60 Madison Ave, 2FL
New York, NY 10010

Spring Health

APPOINTMENT OF REPRESENTATIVE

Use this form if you want Spring Health to grant access to someone other than you to administer your Spring Health services and have access to your personal health information (Third Party Representative) on an ongoing basis **OR** if you are a Legal Guardian or Appointed Legal Representative of a Spring Health Member and are authorized to manage their healthcare.

1. Member Name (First, Last)

_____

2. Member Email

_____

3. Member Date of Birth (MM/DD/YYYY)

_____

Section 1: Type of Request

- ☐ **Third Party Representative (if selected, proceed to Section 2)**
- ☐ **Legal Guardian or Appointed Legal Representative (if selected, proceed to Section 3)**

Section 2: Complete this section to grant a Third Party Representative (parent, spouse, partner, etc.) access to manage your Spring Health services.

I _____ (Your name, the member) appoint _____ (Printed name of third party rep.), _____ (Relationship to you, the member), to act as my representative in connection with my Spring Health benefits, claims and/or treatment. I authorize this individual to make any request; to present or to elicit evidence; submit grievances, to obtain grievance or other information; and to receive any notice in connection with my claims, grievances or requests. I understand that personal medical information related to my care will be disclosed to the representative indicated below, as if they were me.

_____ _____

Member Signature **Date** MM/DD/YYYY

Third Party Representative Contact Information

Email **Phone Number**

Section 3: Complete this section if you are a Legal Guardian or Appointed Legal Representative of a Spring Health Member and are authorized to manage their healthcare.

I _____ are legally authorized to act as the **Legal Guardian or Appointed Legal Representative** representative of _____ in connection with their Spring Health benefits, claims and/or treatment. I'm authorized to make any request(s); to present or to elicit evidence; submit grievances, to obtain grievances or other information; and to receive any notice in connection with their claims, grievances or requests. I'm duly authorized to access and receive personal medical information related to their care as if I were them.

Print your name, the legal guardian

Print the member's name

I am attaching the supporting documentation (e.g., Court Order, Power of Attorney, Guardianship Papers, any other legal representation documentation) for the processing of this request.

Signature **Date** MM/DD/YYYY

Phone Number

Email Address

Mailing Address (number, street, city, state, ZIP code)