# West Virginia Public Employees Insurance Agency (PEIA)

## Provider Contracted Appeal Agent/Advocate Form

This document must be signed by a provider when using a third party to pursue a medical or pharmaceutical claim appeal on behalf of the provider. If the provider fails to sign and submit this form, PEIA will only communicate with the provider listed or the relevant PEIA insured. This form is made pursuant to W. Va. Code §§5-16-1 et seq. and 151 CSR 1.

I, _____, as a provider of medical
(Name of medical and/or pharmaceutical provider)
or pharmaceutical services, affirm that that I contract with the following party to act as my official Agent / Advocate for the purpose of pursuing appeals related to the PEIA insured named on this form.

By signing below, I authorize PEIA to communicate with and exchange personally identifiable information, individually identifiable health information, and/or protected health information with the contracted party for the purpose of payment and health care operations (claims appeals) as defined by 45 CFR §164.501, and as allowed by 45 CFR §164.506 of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA).

| Contracted Appeal Agent / Advocate | PEIA Member Information |
|---|---|
| Name: | Name: |
| Address: | Policy # |
| Phone #: | Date(s) of Service: |
| E-Mail: | Claim(s) #: |

By authorizing the above-listed Agent / Advocate to communicate with PEIA to pursue my provider appeal for the claim(s) specified in this document, I further acknowledge that I am responsible for immediately informing PEIA in the event that this Agent / Advocate is no longer authorized to act on my behalf, and to update this form as necessary.

_____ _____

Signature of the provider Date