**CONSENT FOR PROVIDER TO FILE A FAIR HEARING ON BEHALF OF THE MEMBER**

|  |  |
| --- | --- |
| **Provider Name** | **Provider Plan ID Number** |
| **Provider Address** | **Description of Specific Service or Item for which I agree the Provider Can File a Fair Hearing** |
| **Provider Telephone Number** | **Will Provider be participating with the Member?** |

|  |  |
| --- | --- |
| **Name of Member** | **Member’s Date of Birth** |
| **Member ID No.** |  |
| **Member Mailing Address** |  |
| **Member Daytime Telephone Number** | **Member Evening Telephone Number** |

I, **[Name of Member]**, agree that **[Name of Provider]** canrequest a Fair Hearing for me with Health Partnersor Department of Human Services about the service or item described above. **Note: This is only a consent for the Provider to request a Fair Hearing on behalf of the member. The member MUST attend the Fair Hearing either in person or by telephone as per the Health Choices Member Handbook.**

By signing this consent form, I understand the following:

1. I or my representative may not file a request for a Fair Hearing about the service or item listed in this consent form unless I or my representative takes back my consent for the provider to request a Fair Hearing in writing. I have the right to take back my consent at any time during the Fair Hearing process by telling Health Partnersand **[Name of Provider]** in writing that I do not want **[Name of Provider]** to continue the Fair Hearing process for me.
2. My consent to have the Provider file the request for a Fair Hearing for me will automatically no longer be in effect if the Provider does not file a request for a Fair Hearing or does not continue with the request for a Fair Hearing through the end of the request for a Fair Hearing process.
3. I or my representative has read, or has been read, this consent form, and have explained it to me until I understand it. I or my representative understands the information in this consent form.

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**Signature of Member or Representative Date**

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**Witness Signature**  **Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Print Witness Name**

**If the Member is unable to sign this Consent Form because the Member is legally incompetent:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Person Signing on Behalf of Member**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address of Person Signing on Behalf of Member**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship of Person Signing to Member**

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