Appoint a Representative for My Appeal – Instructions

You have the right to choose a representative to help you with your appeal.

If you want to appoint an appeal representative, complete and submit this form. This form allows your appeal representative to act for you on issues related to your appeal. This form also allows NY State of Health to talk to your appeal representative about your appeal and give your appeal representative information about you. You should choose someone you trust to be your appeal representative.

Your appeal representative can be an authorized representative, a lawyer, a relative, a friend, or another trusted person.

It is important for you to know:

- You do not need to have an appeal representative to qualify for health insurance.
- You do not need to have an appeal representative to make an appeal.
- If you want to have an appeal representative, you must allow your appeal representative to have access to your personal information and information about your health insurance plan.
- Your appeal representative may not be legally required to keep your personal and health insurance information confidential.

The person you choose will stay your representative through the whole appeals process, unless you tell us to remove him or her. To change or remove your appeal representative, or for more information, call NY State of Health at 1-855-355-5777 (TTY: 1-800-662-1220).

This form is good for one appeal at a time. If you ask for another appeal, you must fill out this form again.

Note: An appeal representative is not the same as an authorized representative. If you want someone to be able to sign your health insurance application, submit an update, respond to a redetermination, or act on your behalf with NY State of Health on any issues not related to your appeal, you must choose an authorized representative. To choose an authorized representative, complete form DOH-5085 Authorized Representative Designation Form.

Authorized representatives, legal guardians, those who you have given power of attorney, and others who have legal authority to act on your behalf may sign this form for you if you have given them the power to do so. To let NY State of Health know about these people, follow the instructions on form DOH-5085 or upload to your account the legal document giving someone else the authority to act on your behalf.

How to submit this form

Keep a copy of this for your records. You may submit this form in any of the following ways:

- Upload the form by logging into your account on our website (www.nystateofhealth.ny.gov);
- Fax the form to 1-855-900-5557;
- Mail the form to:

  NY State of Health Appeals Unit

  P.O. Box 11729
  Albany, NY 12211

How to get help with this form

Call NY State of Health at 1-855-355-5777 (TTY: 1-800-662-1220) to get help reading this form in English or other languages or to get this form in other formats like large print.

New York State Department of Health
NY State of Health

Appoint a Representative for My Appeal

SECTION 1 Information About You

Name _____
FIRST NAME, MIDDLE NAME, LAST NAME

NY State of Health Account ID: **AC** _____

Date of birth _____
MM/DD/YYYY

SECTION 2 Information about Your Representative

Name _____
FIRST NAME, MIDDLE NAME, LAST NAME

Mailing address _____ _____
STREET OR PO BOX APARTMENT OR SUITE NUMBER

_____ _____ _____
CITY STATE ZIP CODE

Phone number _____
AREA CODE

Organization name (if applicable) _____

SECTION 3 Your Signature

By signing below, you allow the person in **Section 2** to:

- make or sign your appeal request;
- get official information about your appeal;
- act for you on all future matters related to this appeal; and
- have access to your personal and insurance information.

Note: Signing this form does not authorize your representative to make changes to your NY State of Health account.

Signature _____

Date _____
MM/DD/YYYY

Relationship (if person signing is not on the NY State of Health account) _____