OMB Control Number 3206-xxxx

United States
Office of
Personnel Management
The Federal Government's Human Resources Agency

Multi-State Plan Program

External Review Authorized Representative Form

An enrollee (or "patient") of a Multi-State Plan may use this form to designate an authorized representative to act on his or her behalf regarding the denial of service or payment by his or her health insurance company. By completing and submitting this form, the patient acknowledges that the U.S. Office of Personnel Management (OPM), which conducts external review under the Multi-State Plan Program, will share information about the patient's request for external review with the authorized representative designated on this form.

Submit this completed form to OPM via email at MSPP@opm.gov, or mail it to:

MSPP External Review
National Healthcare Operations
U.S. Office of Personnel Management
1900 E Street, NW
Washington, DC 20415

1. Patient information:

Patient Name	Address, City, State, Zip	Phone	Email	Patient's Member Identification Number

2. Plan information:

Primary Insured Name	Insurance Company	Plan Name	Patient's Relationship to Primary Insured

3. Authorized Representative information:

Authorized Representative Name	Address, City, State, Zip	Phone	Email	Relationship to Patient

4. Patient statements (patient or patient's legal representative, such as parent or legal guardian, to initial each statement)

Patient's Initials	Statements
	I authorize the above-named representative to: • Represent my interests with regard to my external review case that was or will be filed with OPM on _____ (enter date the request for external review was or will be filed). • Deliver to and request and receive from OPM information regarding the above mentioned external review case.
	I understand that OPM and the MSP health insurance company will direct all information regarding the case to the authorized representative, **unless** I provide specific written direction otherwise.
	I may revoke this permission at any time by submitting a request in writing to OPM at mspp@opm.gov or at: MSPP External Review National Healthcare Operations U.S. Office of Personnel Management 1900 E Street, NW Washington, DC 20415

5. Authorized Representative statements:

Authorized Representative's Initials	Statements
	I certify that, to the best of my abilities, I will represent the best interests of the above-named patient regarding the patient's external review case.
	I certify that there is no conflict of interest posed by any relationships I may have with the health insurance company named above, any health care providers from whom the patient is seeking care, or any other party interested in this case.
	I certify that I will not transfer or assign this representation to another party.

_____ _____

Signature of Patient or Patient's Legal Representative *Date*

If signed by a patient's legal representative, also submit a copy of legal authorization (for example: power of attorney, guardianship papers, foster parent certification or court order).

_____ _____

Signature of Authorized Representative noted in item 3 above. *Date*

Privacy Act Statement

In order for you to designate an individual to act on your behalf regarding a request for external review, the U.S. Office of Personnel Management (OPM) requires you to submit this form. Provision of information in the form is voluntary, but omitting any information may not allow you to designate an authorized representative.

Routine uses of your records include the following:

- Disclosure to agency contractors, such as Independent Review Organizations, for the purpose of conducting external review;
- Responses to congressional inquiries initiated by you;
- Investigations of potential violations of law, and judicial or administrative proceedings to which the Federal Government is a party (the information may be provided to another agency, a court, an administrative body, or to the Department of Justice, when the information is arguably relevant to the proceeding);
- Investigations of data breaches and responses to data breaches;
- Disclosure to the National Archives and Records Administration (NARA) or the General Services Administration (GSA) for records management purposes;
- Disclosure to program and policy staff within OPM for statistical and analytical studies or to assist in formulating health program changes; and
- Disclosure to researchers inside and outside of the Federal Government, approved in advance by OPM on the basis of demonstrated aptitude and a written research plan, conducting research on insurance trends and topical issues.

OPM has the authority to administer the Multi-State Plan Program under section 1334 of the Affordable Care Act (42 U.S.C. 18054).

Public Burden Statement

We estimate this form takes an average of 5 minutes to complete, including the time for reviewing instructions, getting the needed data, and reviewing the completed form. Send comments regarding our estimate or any other aspect of this form, including suggestions for reducing completion time, to the Office of Personnel Management, National Healthcare Operations, 1900 E Street, NW, Washington, DC 20415-3430. The OMB Number 3206-XXXX is valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.