

Pharmacy Designation of Authorized Representative (DAR)

In order to recognize someone other than the claimant as an authorized representative, St. Luke's Health Plan's Pharmacy Appeals Department must receive a valid Designation of Authorized Representative form that has been completed by the Plan Participant. Please note, a provider cannot be a designated authorized representative, but can submit additional information to support the appeal.

Plan Participant's Name (print)

Member ID

I hereby authorize the Plan to recognize the person named herein as my designated authorized representative for the purposes described below, and to disclose relevant Protected Health Information (PHI) to:

Name of person representing you

Telephone Number

Street Address

City, State, Zip Code

All Pharmacy Claims

Submit pharmacy Appeals on my behalf

Other (please be as specific as possible):

I understand that this Authorization does not ensure that the person I am authorizing to receive PHI about me will treat such information as confidential. I understand that I may revoke this Authorization at any time by submitting a Cancellation of Designated Authorized Representative Form to Appeals.

This Authorization is valid for one year following the date on which it is signed below unless a different expiration date or event is indicated here _____ or upon receipt by Appeals of a Cancellation of Authorization form, if earlier.

Plan Participant's Signature

Date

Please note, a copy of this authorization form will be sent to your designated representative at the address listed above.

Send to:

St. Luke's Health Plan Pharmacy Benefits Appeals Department

800 East Park Blvd.

Plaza 2, Floor 3

Boise, ID 83712

Phone: (833) 975-1281 | FAX: (833) 850-0171

pharmbenefitmgmntsup@slhs.org