IFEDD
The International Federation of Eating Disorder Dietitians

Access to Care Program Designated Authorized Representative Form for Insurance Assistance

I _____ hereby grant my permission for any member of the IFEDD Access to Care team as well as my dietitian and their billing department representatives to be my authorized representative for purposes of insurance coverage and regulatory intervention, including to help or act on my behalf to advocate for coverage by speaking with my insurance company/representatives, in a complaint to an oversight agency such as a State Insurance Department, Centers for Medicare & Medicaid Services, U.S. Department of Labor, or other regulatory body, and to give consent to a health oversight agency to contact my Health Plan Administrator for details of my insurance plan. I authorize them to share my protected health information and policy details and for my health plan/representative and health oversight agencies to disclose information about my policy, insurance claims, and health information to them and communicate with them without my additional intervention.

I understand I can revoke permission for my Authorized Representative to act on my behalf at any time.

Patient's Legal Name: _____ Relationship: _____

Insurance provider: _____ Member number: _____

Patient's birthdate: _____ My preferred phone number: _____

My preferred email address: _____

Patient's eating disorder diagnosis code: _____ (leave blank if unknown)

Dietitian email address: _____

_____ _____

Signature of Parent or Legal Guardian Today's Date