# **APPOINTMENT OF REPRESENTATIVE**

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier Number (provider as party)	
Section 1: Appointment of Representative		
To be completed by the party seeking representation (i.e., the	Medicare beneficiary, tl	ne provider or the supplier):
I appoint this individual,	ct (the "Act") and relate elicit evidence; to obtai understand that person	ed provisions of Title XI of the Act. In appeals information; and to receive
Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Section 2: Acceptance of Appointment	I	
To be completed by the representative:		
I,, hereby accedisqualified, suspended, or prohibited from practice before the not, as a current or former employee of the United States, discretognize that any fee may be subject to review and approval I am a / an (Professional status or relationship to the party, e.	e Department of Health Jualified from acting as t by the Secretary.	and Human Services (DHHS); that I am
Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Section 3: Waiver of Fee for Representation	I	
Instructions: This section must be completed if the representation representation. (Note that providers or suppliers that are representation and must complete this sec	esenting a beneficiary an	
I waive my right to charge and collect a fee for representing $\_$ DHHS.		before the Secretary of
Signature		Date
Section 4: Waiver of Payment for Items or Services	at Issue	
Instructions: Providers or suppliers serving as a representative must complete this section if the appeal involves a question o (2) generally addresses whether a provider/supplier or benefici know, that the items or services at issue would not be covered	f liability under section a ary did not know, or cou	<b>1879(a)(2) of the Act.</b> (Section 1879(a)
I waive my right to collect payment from the beneficiary for the liability under §1879(a)(2) of the Act is at issue.	e items or services at iss	ue in this appeal if a determination of
Signature		Date

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### Charging of Fees for Representing Beneficiaries before the Secretary of DHHS

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of DHHS (i.e., an Administrative Law Judge (ALJ) hearing, Medicare Appeals Council review, or a proceeding before an ALJ or the Medicare Appeals Council as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR 405.910(f).

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing or request for Medicare Appeals Council review. Approval of a representative's fee is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation.

## **Approval of Fee**

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before DHHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, the ALJ or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

#### **Conflict of Interest**

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.

## Where to Send This Form

Send this form to the same location where you are sending (or have already sent) your: appeal if you are filing an appeal, grievance if you are filing a grievance, initial determination or decision if you are requesting an initial determination or decision. If additional help is needed, contact your Medicare plan or 1-800-MEDICARE (1-800-633-4227). TTY users please call 1-877-486-2048.

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

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