advomas®
Healthcare Eligibility Advocates

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**AUTHORIZATION OF PATIENT REPRESENTATION, AUTHORIZED HEARING REPRESENTATIVE (AHR) AND RETENTION AGREEMENT**

I hereby appoint Advomas to act as my agent to secure payment of my hospital bills. I authorize Advomas to apply and electronically sign for Medicare, Medicaid and/or County assistance (including presumptive and/or retroactive eligibility) and to take any and all steps to obtain documentation needed to secure my benefits. I request that you provide Advomas copies of all notices which would be sent to me regarding my claim. I also authorize Advomas to access my entire electronic and/or hard copy case file, past or present, as well as to discuss my file on my behalf with the Department of Health and Human Services and other applicable federal, state and county program representatives.

For hearings, I appoint Advomas to act as my Authorized Hearing Representative. I authorize Advomas to make any request and further request that you forward to Advomas the hearing summary (with all documents used in the Administrative Hearing(s)), and provide to Advomas copies of all notices, which would be sent to me, including notices of pre-hearing conferences and hearing dates.

I authorize Advomas to act on my behalf to secure payment of my hospital bills from any commercial insurance and to assist in qualifying me for any charity care offered by my provider. Advomas may also act on my behalf, as necessary, to secure COBRA benefits from my employee benefit plan or any third party payer. I request that you provide Advomas copies of all notices which would be sent to me. I also authorize Advomas access to my claim file to obtain any and all records and documents in the file as needed and to discuss my case on my behalf with the insurance carrier, third party payer, benefit fund or plan sponsor.

I understand that, from time to time, Advomas may contact me to discuss the services described in this authorization for past, current or future services provided by the hospital. I authorize Advomas and its service providers, if any, to (a) contact me at any address (including e-mail) or telephone number (including wireless number or ported landline phone number) that I may provide to Advomas or the hospital; and (b) send me text messages to my phone number in connection with the purpose(s) of this authorization. Advomas may share my contact information, including my wireless number and e-mail address, with service providers with whom Advomas contracts to assist it in pursuing these interests, but I understand that Advomas will not share my phone number(s) with third parties for their own purposes without my consent. I understand that standard telephone minute and text charges may apply.

I understand that Advomas is a corporation acting independently of and separate from the hospital; that its services provided to me are paid by the hospital; and the services provided by Advomas will be at no cost to me. A photocopy of this authorization will be considered an original document. This authorization will be in effect until I am approved medical assistance from an applicable payer, a final determination is made that I am not eligible for any medical assistance program, or I withdraw my authorization from Advomas, which I may do by contacting my Advomas representative.

**Patient Name (printed):** _____

Authorizing Person (if other than patient): _____

Authorizing Person Relationship to Patient: ◯ Parent ◯ Spouse ◯ Next-of-Kin ◯ Legal Guardian ◯ Power of Attorney ◯ Other: _____

Signature of Patient or Authorized Person: _____ / *Date:* _____

Form Date: 04/01/2016