UnitedHealth Group®

9102111192126 2

THIS DOCUMENT WAS RECEIVED IN

APPEAL PO BOX 30432 or FAX 801-938-2100, SLC, UT-RMO WEST

FAX

04/29/2021 1650

United Health Group - West, Central and Cirrus RMO
Operated by Firstsource Solutions
1355 South 4700 West
Salt Lake City, UT 84104

UnitedHealthcare®

A UnitedHealth Group Company

9102111192126 2

RECEIVED
VIA
FAX/FTP

BEST COPY AVAILABLE

DO NOT Return to the RMO for Rescan

From: 6514148203 Page: 1/2 Date: 4/29/2021 4:49:59 PM

FAX

9102112119212262

To: John Chianelli
Company:
Fax: 8019382100
Phone:

From:
Fax:
Phone: +1 (913) 335-6830
E-mail:

NOTES:

Attached is an APPEAL Pkt (45 pages) for PT : John Chianelli, dob: 2-8-1965, POLICY # 937011565, for this pt's SOLIRIS (J1300), CASE # A119224073

Provider Information : BRIOVA Infusion Services now OptumRx Infusion, 15529 College Blvd., Lenexa, Kansas 66219, PH # 913-335-6830 Direct Line with secured VM for Jessica C., FAX # 877-542-9352, NPI # 1366603854

Date and time of transmission: Thursday, April 29, 2021 5:07:34 PM
Number of pages including this cover sheet: 45

269CE8AA1002001-03013-02

UnitedHealthcare®

Designation of Authorized Representative

Member Name (*please print*)	Date of Birth	Member ID number	
John Chianelli	2.8.65	937011565	
Member's Street Address	**City**	**State**	**Phone**
4662 South Forest Point Blvd	New Berlin	WI	414-839-5191
Name of Individual/Company/Law Firm being designated as the authorized representative			
Optum Infusion Pharmacy and / or Dr. Juan Figueroa, MD			
Designated Representative's Address	**City**	**State**	**Phone**
15529 College BLVD	Lenexa	KS	913-335-6830
Provider of Service			
Injections			
Date(s) of Service or Proposed Service			
ASAP, Soliris (J1300)			

I, John Chianelli, do hereby
Print the name of the member who is receiving the service or supply

Dr. Juan Figueroa, MD
Print the name of the person who is being authorized to act on the member's behalf

to act as my authorized representative in requesting (*check all that apply*)
___ a complaint X an appeal ___ documents

from UnitedHealthcare regarding the above-noted service or proposed service.

I understand and agree that:

- This authorization is voluntary;
- my health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information;
- I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form;
- my health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulation;
- this authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying UnitedHealthcare in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

Signature of Member:	Date:
John Chianelli, VP	4.23.21
If person signing this authorization is not the member, describe relationship (i.e., parent, legal representative)	