St. LUKE'S CORNWALL HOSPITAL

LIMITED POWER OF ATTORNEY TO PURSUE PAYMENT AND APPEALS AND AUTHORIZATION

TO RELEASE MEDICAL INFORMATION

By signing this document, you give the Hospital the limited power to pursue appeals with and to seek payment from your health insurer, health maintenance organization, or other payor ("Health Plan") for health care services provided to you by the Hospital, and you authorize the release of medical information.

I, _____, residing at _____
appoint The St. Luke's Cornwall Hospital ("Hospital"), located at 70 Dubois Street, Newburgh, NY 12550, and 19 Laurel Avenue, Cornwall, NY 12510, to be my attorney-in-fact and authorized representative to act on my behalf and to take all reasonable actions, as determined by the Hospital, to pursue payment from my Health Plan and/or to pursue any appeals available to me under my Health Plan's policies or procedures and/or under applicable law, including but not limited to external appeals in accordance with New York State and Federal laws, relating to health care services provided by the Hospital. The Hospital will not charge me for its services in pursuing these appeals. If the Hospital appeals and wins these appeals, I agree that my Health Plan will pay monies owed directly to the Hospital for these health care services.

In pursuing such payment and/or appeals:

A. I authorize the Hospital and my Health Plan to release all relevant medical information, including (if applicable) any HIV-related information, mental health treatment information or alcohol/substance abuse treatment information in relation to my treatment necessary to pursue payment from my Health Plan. I understand that this information may be released, but only as necessary to an external appeal agent, arbitrator, court of law or other independent third party reviewer responsible for deciding if a claim must be paid ("Independent Reviewer"). I understand that the Independent reviewer will use this information to make a decision about payment and/or on an appeal. This authorization for the release of my medical records is valid for one year from the date the authorization is signed by me or the Hospital as attorney-in-fact; and

B. I authorize the Hospital to complete, to execute, to acknowledge, to seal and to deliver any consent, demand, request, application, agreement, authorization or other documents necessary, including but not limited to, to request an appeal with my Health Plan and/or an external appeal with the New York State Department of Health, Insurance Department, U.S. Department of Labor, and/or other applicable agency or body.

This Limited Power of Attorney and Authorization shall not be affected by my subsequent disability or incompetence and may be revoked by me at any time upon prior written notice to the Hospital.

IN WITNESS WHEREOF, I have hereunto signed my name this _____ day of _____, 20 _____

YOU SIGN HERE _____

Witness: _____

Print Name/Title:_____

St. LUKE'S CORNWALL HOSPITAL

LIMITED POWER OF ATTORNEY TO PURSUE PAYMENT AND APPEALS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

TO BE SIGNED BY A HOSPITAL REPRESENTATIVE AT A LATER TIME WHEN THE LIMITED POWER OF ATTORNEY IS TO BE USED.

AFFIDAVIT THAT LIMITED POWER OF ATTORNEY IS IN FULL FORCE
(Sign before a Notary Public)

STATE OF NEW YORK
ss:
COUNTY OF

_____, being duly sworn, deposes and says:

1. The Principal within did, in writing, appoint the St. Luke's Cornwall Hospital (the "Hospital") as the Principal's true and lawful ATTORNEY-IN-FACT in the within Power of Attorney.

2. The Hospital has no actual knowledge or actual notice of revocation or termination of the Power of Attorney by death or otherwise, or knowledge of any facts indicating the same. The Hospital further represents that the Principal is alive, has not revoked or repudiated the Power of Attorney, and the Power of Attorney is in full force and effect.

3. The Hospital makes this affidavit for the purpose of inducing _____ _____ (Health Plan or other person or entity) to accept delivery of the following instrument(s), as executed by the Hospital in its capacity as the ATTORNEY-IN-FACT, with full knowledge that this affidavit will be relied upon in accepting the execution and delivery of the instrument(s) and in paying good and valuable consideration therefore.

_____
By:
Name:
Title:
ATTORNEY-IN-FACT

Sworn to before me on this _____ day of _____, 20 _____

_____
NOTARY PUBLIC

St. LUKE'S CORNWALL HOSPITAL

LIMITED POWER OF ATTORNEY
TO PURSUE PAYMENT AND APPEALS
AND TO RELEASE MEDICAL INFORMATION
QUESTIONS AND ANSWERS

This form is designed to offer answers to the most frequently asked questions regarding the Limited Power of Attorney to Pursue Payment and Appeals and to Release Medical Information. Please feel free to ask any additional questions you may have.

1. **What is this Power of Attorney?** This Limited Power of Attorney authorizes the Hospital to pursue payment from your Health Plan in the event your Health Plan denies payment for services provided by the Hospital.

2. **What kinds of legal authority am I giving the Hospital if I sign this form?** By signing this form you authorize the Hospital to appeal on your behalf to your Health Plan. The Hospital will be able to appeal denials to an independent review agent where permitted under New York State and other laws ("Independent Reviewer"). You are also authorizing the Hospital to release your medical records to the Health Plan and/or Independent Reviewer.

3. **Is it possible for the Hospital to use this form to make other decisions on my behalf?** No. The Hospital has no authority to make any other decisions on your behalf, such as those concerning your personal or business affairs or your health care decisions.

4. **Once I sign this Power of Attorney, can I still contact my Health Plan or pursue claims?** Yes. You can still advocate for yourself in any manner you wish to be involved. However, if you are also going to contact the Health Plan regarding a denial of payment for hospital services, we recommend that you keep the Hospital informed so that you and the Hospital can coordinate your efforts to obtain payment.

5. **Will the Hospital charge me a fee for its efforts under the Power of Attorney?** No. The Hospital is seeking payment from your Health Plan for the medial services to you by the Hospital. You will not be charged a fee for the Hospital's efforts to obtain payment.

6. **Will the Power of Attorney remain in effect if I later become disabled or incompetent?** Yes. It remains in effect until you revoke it. The authorization for release of medical records only remains in effect for one year.

7. **What if I later decide I do not want the Hospital to have my Power of Attorney?** You may revoke it at any time. You do this by informing the Hospital in writing that you are revoking the Power of Attorney.