

Power Of Attorney Validation Form

Grantor: _____
 Grantee: _____

POA Effective Date: _____
 POA Review Date: _____
 Intermountain Legal Contact: _____
 Account #(s): _____
 Account #(s): _____

Please provide direction as to whether the POA is valid for the areas checked below:

(X)	Element / Topic	Yes	No	Comments from Legal
<input type="checkbox"/>	Financial (e.g., Payment History, Requesting Refund, Transfer of Payment, UGOP, Financial Assistance, Dispute, Credit Reporting, Payment Arrangements)			
<input type="checkbox"/>	Billing Information (e.g., Charges, Date of Service, Type of Service, Physician Information, Insurance Processing Information)			
<input type="checkbox"/>	Correspondence (e.g., Debtor Statements, Itemized Statements, Facility Letters)			
<input type="checkbox"/>	Durable POA			
<input type="checkbox"/>	Restrictions/Limitations (Does the POA include any specific restrictions, limitations)			
<input type="checkbox"/>	Access to Medical Records			
<input type="checkbox"/>	Medical Decision-making for Patient			

Submitted by: _____ Department: _____ Phone Number: _____