

Authorization of Representative

For purposes of pre- or post-service claim appeal



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Section 1

I, _____, authorize _____ to act on my behalf to pursue the following appeal of an adverse benefit determination:

Date of Service _____ or Pre-Service _____

Type of Service _____

Provider _____

This authorization is limited to the appeal of the designated claim.

Section 2

Member Information:

Name _____
Last First MI

Address _____
Street

City State ZIP Code

Telephone No. (_____) _____
Area Code

Fax No. (_____) _____
Area Code

ID No. _____

Section 3

Authorized Representative Information:

Name _____
Last First MI

Address _____
Street

City State ZIP Code

Telephone No. (_____) _____
Area Code

Fax No. (_____) _____
Area Code

Provider No. (if applicable) _____

Member Signature  _____ Date _____