Authorization of Representative

for purposes of pre- or post-service claim appeal

Section 1 – Appeal Information

I, ______________________________, authorize ______________________________
Member Name — Authorized Representative Name

to act on my behalf to pursue the following appeal of an adverse benefit determination:

_____ /_____ /_______ or _____ /_____ /_______
Date of Service — Date of Pre-Service

______________________________ ______________________________
Type of Service — Provider of Service

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

Section 2 – Patient Information

First Name | MI | Member ID Number

Last Name | Suffix | (_____) _____-________ Home Phone Number | (_____) _____-________ Fax Number

Residential Address

City

State | ZIP Code | +4

Section 3 – Authorized Representative Information

First Name | MI | Provider Number (if applicable)

Last Name | Suffix | (_____) _____-________ Home Phone Number | (_____) _____-________ Fax Number

Residential Address

City

State | ZIP Code | +4

Section 4 – Authorization

Your signature required

______________________________ _____ /_____ /_______
Patient Signature/Parent of Minor Child/Guardian of Patient — Date Signed

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