Authorization of Designated Representative to Appeal A Determination

TO:

Date: _____

Name: _____ Member #: _____
(Please Print)

I hereby authorize _____ to appeal determination
(Print Doctor's Name or Representative)

concerning my medical bills on my behalf, as my Designated Representative, and as part of the appeal, I hereby authorize my insurance company to disclose and furnish to my Designated Representative:

All medical and financial information contained in my insurance file including but not limited to treatment for venereal disease, alcoholism and drug abuse, abortion, mental disorder or developmental disability, cancer and HIV status relating to my examination, treatment and hospital confinement in connection with the determination which is being appealed. I understand this information is privileged and confidential and will only be released as specified in this authorization. This authorization is valid for a period of one year.

Signature of Member or Legal Guardian/Representative: _____

Signature of Witness/Designated Representative (Circle One) _____

Name of Witness/Designated Representative (Please Print) _____

Title (if on provider's staff) or Relationship to member: _____