Member Consent for Provider to File an Appeal on my Behalf with Health Insurance Plan

1. Provider name: _____
2. Provider plan ID number: _____
3. Provider address: _____
4. Provider phone number: _____
5. Description of services that are being appealed: _____
6. Date(s) services were or are to be provided: _____
7. I agree to allow this health care provider to file an appeal on my behalf with the following health plan, if there is a question about coverage for the services listed above. _____
8. I understand that:
   - If I consent, I will not be able to file my own appeal concerning these same services, nor will any representative I appoint, unless this consent is rescinded in writing. _____
   - I have a right to rescind this consent at any time. My legal representative has the right to rescind this consent at any time. _____
   - This consent shall be automatically rescinded if my health care provider does not file an appeal, or discontinues my appeal. _____
   - I have read this consent or have had it read to me, and it has been explained to my satisfaction. _____

9. I understand the information in the consent form, and grant my consent to this provider to file an appeal on my behalf.

    a. Print member name: _____

    b. Member date of birth: _____

    c. Health insurance company: _____

    d. Member insurance ID number: _____

    e. Member address: _____

    f. Member signature: _____

    g. Signature date: _____

10. The above-named member is unable to sign this consent form because of the following reason(s): _____

    I consent for the above-named member:

    a. Print representative name: _____

    b. Representative signature: _____

    c. Signature date: _____

    d. Print witness name: _____

    e. Witness signature: _____

    f. Signature date: _____

Return the completed authorization form in one of the following ways:

- **Mail:**

  Member Appeals Department
  P.O. Box 41820
  Philadelphia, PA 19101-1890

- **Fax:** 215-988-6558 or 1-888-671-5274 (toll-free)

Member Appeal Consent Form Completion Instructions

Please note: The form must be fully completed for the appeal process to start.

1. **Provider Name:** The name of the provider you are designating to file your appeal.
2. **Provider Plan ID Number:** The provider's plan ID number. *The doctor must supply this.*
3. **Provider Address:** The address of the provider you designate to file your appeal.
4. **Provider Phone Number:** The phone number of the provider you designate to file your appeal.
5. **Description of services that are being appealed:** Please explain the services that are being appealed.
6. **Date(s) services were or are to be provided:** The date that the services were provided or are going to be provided.
7. **I agree to allow this health care provider to file an appeal on my behalf with the following health plan, if there is a question about coverage for the services listed above.** This statement indicates that you are permitting the provider you designate to file the appeal for you.
8. Please read these statements to be sure you understand this process. **I understand that:**
   - If I consent, I will not be able to file my own appeal concerning these same services, nor will any representative I appoint, unless this consent is rescinded in writing.
   - I have a right to rescind this consent at any time. My legal representative has the right to rescind this consent at any time.
   - This consent shall be automatically rescinded if my health care provider does not file an appeal, or discontinues my appeal.
   - I have read this consent or have had it read to me, and it has been explained to my satisfaction.
9. **I understand the information in the consent form, and grant my consent to this provider to file an appeal on my behalf:** Your signature indicates that you understand the consent form and its use.
   a. **Print Member Name:** Print the name of the member.
   b. **Member Date of Birth:** The member's date of birth.
   c. **Health Insurance Company:** The name of your health insurance company.
   d. **Member Insurance ID Number:** The identification number which is found on your member ID card.
   e. **Member Address:** The member's address.
   f. **Member Signature:** The member must sign the consent form.
   g. **Signature Date:** The date the consent form was signed.
10. **The above-named member is unable to sign this consent form because of the following reason(s):**

    Please indicate any reason why the member is not able to sign the consent form, if applicable.

    To be completed if the member is unable to sign the consent form. **I consent for the above-named member:**

    a. **Print Representative Name:** The name of the provider submitting the consent form on behalf of the member.
    b. **Representative Signature:** The representative's signature
    c. **Signature Date:** The date the representative signed the form.
    d. **Print Witness Name:** Print the name of the person witnessing the signature of the representative.
    e. **Witness Signature:** The signature of the witness.
    f. **Signature Date:** The date the witness signed the form.