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Member Authorization Form for a Designated Representative to Appeal a Determination

TO: _____
[Your Insurance Carrier's Name]

_____

_____

Date: _____

Member Name: _____

Member#: _____

I hereby authorize Irving Orthopedics & Sports Medicine/Southwest Spine Institute to appeal _____'s determination concerning my coverage for medical care provided on _____ on my behalf, as my Designated Representative, and, as part of the appeal, I hereby authorize_____ to send all decision letters in connection with the processing of my claim and to communicate with my Designated Representative in all aspects of the appeal. I understand that these communications may contain medical and financial information that relates to my appeal.

[Your Insurance Carrier's Name]

[Date(s) of Service]

[Your Insurance Carrier's Name]

I understand this information is privileged and confidential and will only be released as specified in this Authorization, or as required or permitted by law. This authorization is valid for a period of one year.

_____
Members or Legal Guardian

_____
Designated Representative Signature

_____
Designated Representative (Print Name)