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Patient Consent for Providers to File an Appeal

Description of Service(s) that may be appealed:	Date(s) service was provided:
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Member Information and Consent:

I have read this consent and agree to allow the provider listed above to file an appeal on my behalf with my insurance carrier and/or employer group.

Patient Name (print): _____

Date of Birth: _____ Member ID#: _____

Address: _____

Patient Signature: _____ **Date:** _____

The Patient listed above is unable to sign this consent form because of the reason(s) listed below and I consent for the patient:

Representative Name: _____

Designated Representative Signature: _____

Relationship to Patient: _____ Date: _____

Witness Name:

Witness Signature: _____ Date: _____