



**CONSENT FOR PROVIDER TO FILE AN APPEAL
ON BENEFICIARY'S BEHALF**

PROVIDER INFORMATION:

Provider Name:	Provider NPI:
Group Name:	Phone Number:
Address, City, State and ZIP:	

DESCRIPTION OF SERVICES TO BE APPEALED, INCLUDING DATES OF SERVICE*: _____

***Please be sure to also include all necessary clinical and other supporting documentation for the appeal.**

BENEFICIARY INFORMATION AND CONSENT: I give consent for the provider listed above to file an appeal on my behalf with TRICARE Prime® Demo by CareSource Military & Veterans™. This will be an appeal of the denial of health care services issued by TRICARE Prime® Demo that is described above. I have read this consent or have had it read to me and it has been explained to my satisfaction.

Beneficiary Name:	Beneficiary ID:	Date of Birth:
Address, City, State and ZIP:		Phone Number:
Beneficiary Signature:		Date:

CONSENT FROM A REPRESENTATIVE: The beneficiary listed above is unable to sign this consent form because of the reason(s) listed below, and I consent for the beneficiary: _____

If signed by someone other than the beneficiary/minor beneficiary's parent, you must provide a copy of the power of attorney or court document showing authority to act on the beneficiary's behalf, if you have not already done so. Please complete the following fields:

Representative Name:	Representative Phone Number:	Relationship to Beneficiary:
Representative Signature:		Date:



Witness Name:	Witness Signature:	Date:
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