HAP CareSource™

Consent for Provider to File an Appeal on Patient/Member's Behalf

Provider Information

Provider First and Last Name:	Provider National Provider Identifier (NPI):
Group Name:	Provider Phone Number:
Provider Address, City, State and ZIP:	

Describe the services to be appealed. Include dates of service and all necessary clinical and supporting documentation for the appeal:

_____

_____

Member Information and Consent: I consent for the provider named above to file an appeal on my behalf with HAP CareSource™ MI Health Link (Medicare-Medicaid Plan). The appeal is for the denial of health care services issued by HAP CareSource MI Health Link (described above). I have read this consent form, or it has been read to me and fully explained.

Complete the following:

Member First and Last Name:	Member ID:	Member Date of Birth:
Member Address, City, State and ZIP:		Member Phone Number:
Member Signature:		Date:

☐ **Consent from a Representative:** The member above is unable to sign this consent form because of the reason(s) below, and I consent for the member:

Representative Signature: _____ Date: _____

Reason(s) the member is unable to sign this consent form:

_____

_____

<u>If signed by someone other than the member/minor member's parent or legal guardian:</u> Include a copy of the Power of Attorney or court document which proves your authority to act on the member's behalf, if not already presented.

Complete the following:

Representative Name:	Representative Phone Number:	Relationship to Member:
Representative Signature:		Date:
Witness Name:	Witness Signature:	Date: