



**CONSENT FOR PROVIDER TO FILE AN APPEAL ON
PATIENT/MEMBER'S BEHALF**

PROVIDER INFORMATION:

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

TELL US THE SERVICES YOU WANT TO APPEAL. INCLUDE DATES OF SERVICE*:

***Please be sure to give us all the clinical and other support documents needed for the appeal.**

MEMBER INFO AND CONSENT: I give consent for the provider listed above to file an appeal on my behalf with CareSource. This will be an appeal of the denial of health care services issued by CareSource. These services are described above. I have read this consent or have had it read to me. It has been explained to me so that I understand.

Member Name:	Member ID:	Date of Birth:
Address, City, State and ZIP:		Phone #:
Member Signature:	Date:	

△ CONSENT FROM A REPRESENTATIVE: The member listed above cannot sign this consent form. This is because of the reason(s) listed below. I consent for the member: _____

If signed by someone other than the member/minor member's parent, you must give us a copy of the power of attorney or court document showing you can act on the member's behalf. Please fill out the fields below:

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