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

MEMBER INFORMATION 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> that is described above. I have read this consent or have had it read to me and it has been explained to my satisfaction.

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

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

_____

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

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