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: