Member Consent for Provider or Representative to File an Appeal

If you need help filling out this form, call us at 800-299-6080. (Si necesita ayuda para llenar o completar este formulario, llamenos al 800-299-6080.) If you are deaf or hard of hearing, call 711 for assistance. Please print all information, except signature.

Member Information

Provider Name_____ NPI Number_____

Vendor/Group Name_____ Phone Number_____

Full Address_____

Description of Action You Want to Appeal (You may Attach Additional Information)

Member Information and Consent: I give consent for my provider to appeal for me, to MHC. The appeal will be for the action taken by MHC, noted above. I have read this consent or have had it read to me. The reason for the appeal was explained to me. I am aware of the information in the consent form.

Member Name_____ Member ID Number_____

Address_____ Phone Number_____

Member Signature_____ Date_____

Consent from a Designated Representative

The member is unable to sign the consent form because of…

I am authorized to give consent on behalf of the member.

Representative Name_____

Relationship to Member_____

Representative Signature_____ Date_____

Witness Name_____

Witness Signature_____

Date_____

After completing this form, please submit by faxing it to 1-559-243-7012 or emailing it to UMFax@healthcomp.com.

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