Member Authorization for Internal Appeal

Attention:	**Blue Cross and Blue Shield – Triage**	
IL:	**PO Box 2401, Chicago, IL 60690**	**Fax: 918-551-2011**
OK:	**PO Box 3283, Tulsa, OK 74102**	**Fax: 918-551-2011**
TX:	**PO Box 660044, Dallas, TX 75266**	**Fax: 918-551-2011**
MT:	**PO Box 4309, Helena, MT 59604**	**Fax: 918-551-2011**
NM:	**PO Box 27630, Albuquerque, NM 81725**	**Fax: 918-551-2011**

This must be completed prior to returning to BCBS.
Patient Name:
Group Number:
Subscriber Number:
Provider Name:
Claim Number(s) or Service Description:
Dates of Service:
Person / Entity authorized to appeal on your behalf:

Please note:

- If you are the patient and are 18 years of age or older, your signature is required.
- If the patient is a minor and you are the patient's Parent, Guardian or Authorized Representative, please sign your name below with the date and include your relationship to the patient.

If this consent is signed by someone other than the patient and the patient is over 18 years of age THIS CONSENT WILL NOT BE ACCEPTED unless an authorization is on file to release the patient's Protected Health Information. If you have any questions please contact the customer service number located on the back of the member ID card.

Yes, I authorize the person noted above to appeal on my behalf. I understand that by doing so this <u>may</u> waive my right to submit an appeal at a later date. I am aware that I may submit additional information to be included with the appeal.

_____ _____

Signature Date

_____ _____

Printed Name Relationship to Patient

No, I do not consent to assign my appeal rights to anyone.

_____ _____

Signature Date

_____ _____

Printed Name Relationship to Patient