



An Independent Licensee of the
Blue Cross and Blue Shield Association

HMO & PPO Appeals
PO Box 44197
Jacksonville, FL
32231-4197

APPOINTMENT OF REPRESENTATIVE FORM

PATIENT'S NAME

SUBSCRIBER'S CONTRACT NUMBER

APPOINTMENT OF REPRESENTATIVE

I appoint _____
(name of representative) to act as my representative in connection with my appeal.

I authorize this individual to make or give any request or notice; present or elicit evidence; to obtain information; including, without limitation, the release of past, present, or future: HIV test results, alcohol and drug abuse treatment, psychological/psychiatric testing and evaluation information, and any other information regarding medical diagnosis, treatments and/or conditions; and to receive any notice in connection with my pending appeal or asserted right wholly in my stead.

SIGNATURE (patient, parent, or guardian))

ADDRESS

TELEPHONE NUMBER (area code)

DATE

ACCEPTANCE OF APPOINTMENT

I, _____, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not as a current or former officer or employee of the United States, disqualified as acting as the claimant's representative; that I will not charge or receive any fee for the representation unless it has been authorized in accordance with the laws and regulations.

I am a/an

(Attorney, union representative, relative, etc.)

SIGNATURE (Representative)

ADDRESS

TELEPHONE NUMBER (area code)

DATE



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"si desea este documento en Español, llame al 1-877-352-2583"