MEMBER CONSENT FOR PROVIDER REPRESENTATION DURING THE APPEAL OR COMPLAINT PROCESS

I designate and authorize the provider listed below to represent me and act on my behalf in all aspects of the appeal or complaint proceeding with Univera Healthcare for the following service, which is being denied, reduced, suspended or stopped.

____

(Description of service as indicated on correspondence from the health plan, including the reference number)

I understand that this consent will apply to any appeal or complaint proceeding for the service listed above only, and I must complete, sign and submit a separate consent form for an appeal or complaint related to another service.

I also understand that I can change my representation designation at any time by contacting the health plan.

Member Name (print):____

Member Identification Number (from health plan identification card):______________________________

Street Address:____

City, State, ZIP code:____

Home Phone: _____________________________ Cell Phone: ______________________________

Member Signature: _______________________________________ Date: ____________________

I designate the following provider to represent me and act on my behalf:

Provider Name (print):____

Practice Name:____

Street Address:____

City, State, ZIP code:____

Phone: ____________________ Fax: _________________ email:_____________________

Provider Signature: __________________________________ Date: ____________________

Mail To: Univera Healthcare, P.O. Box 4717, Syracuse, NY 13221 **Fax to**: 315-671-6656