Florida Blue

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

_____ _____

MEMBER NAME **POLICYHOLDER'S MEMBER ID NUMBER**

APPOINTMENT OF REPRESENTATIVE

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

As my representative and in my stead, I authorize the above-named individual (for the specific and exclusive purpose of representing my interests and exclusively and only for this appeal) to make or give any request or notice on my behalf; present or elicit evidence supporting my appeal; obtain information necessary for this appeal; 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 my medical diagnoses, treatments and/or conditions; and to receive any notice in connection with my pending appeal or asserted rights.

Please enter a specific description of the health care service with respect to which this appeal is being submitted (e. g. description of service that was denied, the date of service and claim number, specific procedure and/or diagnosis codes (if applicable):

_____

(Attach additional sheets if more space is needed)

_____ _____

SIGNATURE (member, parent, or guardian) **ADDRESS**

_____ _____

TELEPHONE NUMBER (area code) **DATE**

ACCEPTANCE OF APPOINTMENT

I, _____, a natural person, hereby accept the above appointment. I understand that I cannot assign this appointment to another individual and that any attempt to do so is invalid. 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: 1) it has been authorized in accordance with the laws and regulations and 2) I have fully disclosed, to the member, parent or guardian above, the amount and method of remuneration/compensation that I have received or expect to receive in connection with my representation of the member.

I am a/an _____

(Attorney, union representative, relative, etc.)

_____ _____

SIGNATURE (Representative) **ADDRESS**

_____ _____

TELEPHONE NUMBER (area code) **DATE**

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