ADVANCED
NEUROSURGERY
ASSOCIATES

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Member Authorization Form for a Designated Representative to Appeal Adverse Determination

Date: _____

Member Name: _____

Member#: _____

To Whom It May Concern:

I authorize Advanced Neurosurgery Associates to act as my representative in connection with complaint, grievance, appeal with_____.

I authorize this group to make any request; to present or elicit evidence; to obtain information; and to receive any notice in connection with my complaint, grievance or appeal. I understand that personal health information related to my claim may be disclosed to my representative in the course of complaint, grievance or appeal.

I have read this consent or had it read to me and it has been explained to my satisfaction. I understand this information, and grant my consent for my representative to file a complaint, grievance or appeal on my behalf.

_____
Date

_____
Patient Name: (please print)

_____
Patient Signature:

_____
DOB: