Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

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 Excellus BlueCross BlueShield 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: Excellus BlueCross BlueShield, P.O. Box 4717, Syracuse, NY 13221 **Fax to**: 315-671-6656