Air Medical Transport Services provided by Air Methods Corporation

DEFENDERS OF TOMORROW™

Designation of Representative (DOR)

Please fill out all fields and return in the enclosed postage paid envelope.
For help on filling out the form, contact us at:

(855) 896-9067

patientforms@airmethods.com

DATE:

MEMBER NAME:

MEMBER #:

REFERENCE #:

I hereby authorize to appeal a benefit determination, concerning an underpayment or denial on my behalf, as my Designated Representative, and as part of the appeal, I hereby authorize in its decision letter and in connection with the processing of my appeal, to communicate with my Designated Representative in all aspects of the appeal.

I understand this information is privileged and confidential and will only be released as specified in this authorization, or as required or permitted by law. This authorization is valid for a period of one year.

_____
Signature of Member or Legal Guardian/ Representative

_____

☐ Signature of Witness ☐ Designated Representative (Check One)

_____
Name of Witness/Designated Representative (Please Print)

_____
Title (if on provider's staff) or Relationship to Member