AUTHORIZED REPRESENTATIVE

Contract Number:

Patient Name:

Claim Number:

Date of Service:

Your group benefit plan provides you the right to file claims, appeal our decision and obtain information from us about the basis for our denial. If you do not wish to exercise these rights on your behalf, you may use this form to designate someone to act as your agent. You should carefully consider whether to designate an authorized representative and, if so whom. Please forward the completed form to:

Blue Cross and Blue Shield of Alabama
Attention: Customer Service Appeals
P.O. Box 12185
Birmingham, AL 35202-2185

Name of Authorized Representative			
Address			
City	State	Zip	Telephone Number (including area code)

Please provide the dates of service and/or claim number(s) for which you would like to be represented by the above named person. This representative will only receive correspondence pertaining to dates listed.

Claim Number and/or	Dates Service
Subscriber's Signature	Date

Blue Cross and Blue Shield of Alabama is an independent licensee of the Blue Cross and Blue Shield Association.