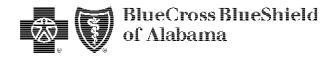
11/29/2017 3:01 PM BCFAX2 -> Fax Server Page 2 of 2



AUTHORIZED REPRESENTATIVE

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:

Contract Number:

Patient Name:

Claim Number:

Date of Service:

Blue Cross and Blue Shield of Alabama Attention: Customer Service Appeals P.O. Box 12185 Birmingham, AL 35202-2185					
Name of Authorized Representative	е				
Address					
City	State	Zip	Telephone Nu	umber (including area code)	
•			-	uld like to be represented by ce pertaining to dates listed.	
Claim Number and/or				Dates Service	
Subscriber's Signature		Date	Date		

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