Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Designation of Authorized Representative for Appeal

Use this form to authorize an individual to file an appeal and communicate on your behalf with Blue Cross Blue Shield of Michigan on a one-time basis regarding the specific appeal.

Your name	Enrollee ID Number (number on your card beginning with 1 to 3 letters)
Patient's name (if different from yours)	

Please complete the information to name your authorized representative below:

Name of the person who is the authorized representative		Authorized representative's daytime phone
Address of authorized representative		
City	State	ZIP

Please complete the following information regarding your appeal:

Date of service:	Provider name:
Claim amount:	Location of service:

Briefly describe the matter in which the authorized representative can speak on your behalf:

I authorize Blue Cross Blue Shield of Michigan to communicate with my authorized representative about my appeal, as well as to release health or medical information and medical records in connection with this appeal to him/her.

I give BCBSM permission to disclose to my named representative protected health information that is relevant to the appeal stated above. My personal representative may use the information received by BCBSM only to help me resolve the above appeal and may not use it for any other purpose or disclose it to anyone else without my written permission.

☐ Check here if your appeal is regarding one of the conditions indicated below and this authorization Includes the disclosure of PHI regarding these services or conditions:

Testing or treatment for AIDS, AIDS-related complex or HIV
Substance abuse (including alcoholism)
Mental health services (including eating disorders, excluding psychotherapy notes)

Signature:_____ Date: _____