BlueCross BlueShield of South Carolina and
BlueChoice® HealthPlan of South Carolina

Independent licensees of the Blue Cross and Blue Shield Association

Designation of Authorized Representative to Appeal

I, _____(member name), authorize the individual or entity listed below to act on my behalf as my authorized representative to pursue an appeal of the specific claim(s) noted below. **This designation is limited to the specific claim(s) listed below.**

Section I: Claim Information

Claim Number: _____

Date of Service: _____

Total Charge(s): _____

Provider: _____

Additional Claim Number (if applicable): _____

Additional Claim Number (if applicable): _____

Section II: Member Information

Name: _____ Date of Birth: _____

Mailing Address: _____

Member ID Number: _____ Telephone Number: _____

Section III: Authorized Representative Information

Name: _____

Mailing Address: _____

Telephone Number: _____ Fax Number: _____

Relationship to Member: _____

Provider Number (if applicable): _____

Member Signature: _____ **Date:** _____