

Insurance Carrier: _____

Member Appeals Authorization

This form is used to obtain authorization from the member to identify a specific representative to file medical appeals on their behalf.

Member/Subscriber Information:

Name: (First, Middle Initial, Last, Title{Sr., Jr., III})	Date of Birth: (Month/Day/Year)
Address: _____ _____	Day Telephone Number: _____
Identification Number (Contract Number): _____	

I authorize _____ and its affiliates to disclose the above individual's protected health information relating to the specific claim(s) listed below to:
University Orthopaedic Associates, LLC 732-545-0400
215 Easton Avenue
New Brunswick, NJ 08901.

The purpose of this disclosure is to appeal services rendered by University Orthopaedic physicians that were not paid according to industry standards.

This authorization will expire 1 year after termination of enrollment with _____. I understand I may revoke this authorization at any time.

Date of Service

CPT – Procedure Description

Date

Patient's Signature

I understand the nature of this release. I also understand that the organization I authorized to receive the information described above is subject to federal health information privacy laws and they may not further disclose the protected health information. I understand that authorizing the use and disclosure of my information is to a condition of enrollment in this health plan, eligibility of benefits or payment of claims.

Insurance Carrier Name

Patient Name

Plan

Insured's Identification Number

Member's Signature