

Provider Information

Provider name _____ NPI # _____

Group name _____ Phone _____

Address, city, state zip _____

Description of service(s) that may be appealed:

Date(s) service was provided:

Member Information and Consent

I agree to allow the provider listed above to file an appeal for me with First Choice for the services listed*. I have read this consent or have had it read to me and it has been explained to my satisfaction. I understand the information in the consent form and give my consent to this provider to file an appeal for me.

Patient name (print) _____ Date of birth _____ Member ID # _____

Address _____ Phone _____

Patient signature _____ Date* _____

**Consent cannot be dated before the service(s) in question.*

Consent from a Designated Representative

The patient listed above is unable to sign this consent form because of the reason(s) listed below and I consent for the patient:

Representative name (print) _____ Relationship to patient _____

Representative signature _____ Date _____

Witness name _____ Signature _____ Date _____