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Patient Consent for Authorized Representative to File an Appeal on my Behalf

Name of Provider or Authorized Representative:	Provider Plan ID Number (if applicable):
Address:	
Description of services that may be appealed:	Date(s) services were provided:

I agree to allow this health care provider or other Authorized Representative to file an appeal on my behalf with WellAway if there is a question about coverage for the services listed below.

I understand that:

1. If I consent, I will not be able to file my own appeal concerning these same services, nor will any other representative I appoint, unless this consent is rescinded in writing.
2. I have a right to rescind this consent at any time. My legal representative has the right to rescind this consent at any time.
3. This consent shall be automatically rescinded if my health care provider or Authorized Representative does not file an appeal, or stops appealing my case.

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 grant my consent to this Authorized Representative to file an appeal on my behalf.

Print Patient Name:	Patient Date of Birth:	Health Insurance Company:

Patient Address:	Patient Member ID Number:
Patient Signature:	Signature Date:

The above named enrollee is unable to sign this consent form because of the following reasons and I consent for the above named enrollee:

Print Representative Name:	Relationship to the Patient:
Representative Signature:	Signature Date:

Print Witness Name:	Witness Signature:	Signature Date: