Florida Blue
An Independent Licensee of the
Blue Cross and Blue Shield Association

HMO & PPO Appeals
PO Box 44197
Jacksonville, FL
32231-4197

APPOINTMENT OF REPRESENTATIVE FORM

PATIENT'S NAME _____ **SUBSCRIBER'S CONTRACT NUMBER** _____

APPOINTMENT OF REPRESENTATIVE

I appoint _____
(name of representative) to act as my representative in connection with my appeal.

I authorize this individual to make or give any request or notice; present or elicit evidence; to obtain information; including, without limitation, the release of past, present, or future: HIV test results, alcohol and drug abuse treatment, psychological/psychiatric testing and evaluation information, and any other information regarding medical diagnosis, treatments and/or conditions; and to receive any notice in connection with my pending appeal or asserted right wholly in my stead.

SIGNATURE (patient, parent, or guardian)) _____ **ADDRESS** _____

TELEPHONE NUMBER (area code) _____ **DATE** _____

ACCEPTANCE OF APPOINTMENT

I, _____**, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not as a current or former officer or employee of the United States, disqualified as acting as the claimant's representative; that I will not charge or receive any fee for the representation unless it has been authorized in accordance with the laws and regulations.**

I am a/an
_____
(Attorney, union representative, relative, etc.)

SIGNATURE (Representative) _____ **ADDRESS** _____

TELEPHONE NUMBER (area code) _____ **DATE** _____

Florida Blue
An Independent Licensee of the
Blue Cross and Blue Shield Association

HMO & PPO Appeals
PO Box 44197
Jacksonville, FL
32231-4197

"si desea este documento en Español, llame al 1-877-352-2583”