Member Consent for Provider or Representative to File an Appeal

If you need help filling out this form, call us at 855-447-2900. (Si necesita ayuda para llenar o completar este formulario, llamenos al 855-447-2900.) If you are deaf or hard of hearing, you can call Utah Relay Services at 711 or 1-800- 346-4128. (Si habla español, puede llamar a Spanish Relay Utah al 1-888-346-3162.) These are free public telephone relay services or TTY/TDD. (Estos son servicios gratuitos de retransmisión telefónica pública o TTY / TDD.) Please print all information, except signature.

Provider Information:

Provider Name: _____ NPI #: _____

Vendor/Group Name: _____ Phone #:_____

Address (city, state, zip): _____

_____

Description of action you want to appeal (you may attach additional information):

Member Information and Consent: I give consent for my provider to appeal for me, to MHC. The appeal will be for the action taken by MHC, noted above. I have read this consent or have had it read to me. The reason for the appeal was explained to me. I am aware of the information in the consent form.

Member Name: _____ Member ID #: _____ Date of Birth: _____

Address: _____ Phone #: _____

Member Signature: _____ Date*: _____

Consent from a Designated Representative:

The member is unable to sign the consent form because of _____

_____ I

am authorized to give consent on behalf of the member.

Representative Name: _____ Relationship to member: _____

Representative Signature: _____ Date: _____

Witness Name_____ Signature_____ Date: _____