Designation of Authorized Appeal Representative

Plan participant name	Identification number of plan participant

Arkansas Blue Cross and Blue Shield will accept appeals submitted on your behalf by an authorized appeal representative. In order to properly designate someone else to pursue an appeal on your behalf, Arkansas Blue Cross and Blue Shield requires that you and the person you wish to designate as your Authorized Appeal Representative must each sign this form, indicating that both you and the person you designate as your Authorized Appeal Representative agree to the terms and conditions stated in this form. If you or your designated Authorized Appeal Representative do not agree to any statements or terms set forth in this form, do not sign this form.

Once you and your designated Authorized Appeal Representative have each signed this form and returned it to Arkansas Blue Cross and Blue Shield at the address listed below, please understand that you have authorized the following to occur:

1. By signing this form, you give permission for the Authorized Appeal Representative to exercise your appeal rights under the Plan.
2. Your signature on this form also gives the Authorized Appeal Representative access to all of your medical information and claims for health care benefits under the Plan, to the extent that any of them are relevant to your appeal.
3. Your signature on this form authorizes the Plan and any of its representatives, to communicate directly with the Authorized Appeal Representative with regard to your appeal, as well as communicate all related information such as claims, medical records, explanations of benefits, telephone calls, correspondence, your address, telephone numbers, social security number and Plan identification numbers, premium payments or other Plan eligibility data related to the appeal.
4. Upon proper submission of this signed form, Arkansas Blue Cross and Blue Shield, will communicate directly to your Authorized Appeal Representative – rather than to you – the decision regarding your appeal, as well as other information related to the appeal.

If you wish to designate an appeal representative, please complete parts A through D of this form and forward it to Arkansas Blue Cross and Blue Shield at the address shown at the bottom of this form.

A. Identification of claims you wish to appeal

Please list the claims you authorize the Authorized Appeal Representative to appeal for you:

Name of health care provider	Date(s) of service	Amount you claim is owed by plan

NOTE: If all claims will not fit in the spaces provided above, you may submit an additional page, showing the requested details; however, the additional page MUST BE SIGNED AND DATED BY YOU or it will not constitute a valid authorization for the Authorized Appeal Representative to represent you with respect to appeal of any such identified claims.