Amerigroup

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Member consent for appeal form

Appeal number:

Member name:

Parent or guardian name (if the member is a child or you are a legal guardian/authorized representative*): _____

Member ID number:

Doctor who will act on your behalf:

Service or treatment you're appealing:

_____

_____

_____

_____

By signing this form, I agree that the doctor noted above may act on my behalf for this appeal.

Sign: _____ **Date:** _____

Member, parent, legal guardian or authorized representative*

Mail this signed form to:

Attn: Appeals department
Amerigroup Washington
705 Fifth Ave. S., Suite 300
Seattle, WA 98104

Or fax it to 844-759-5953.

*An authorized representative must be chosen by the member, parent or legal guardian. A doctor may represent the member with the member's/responsible party's written consent. An authorized representative cannot make health care decisions about the financial responsibility of the member, parent or legal guardian unless it's put in writing.