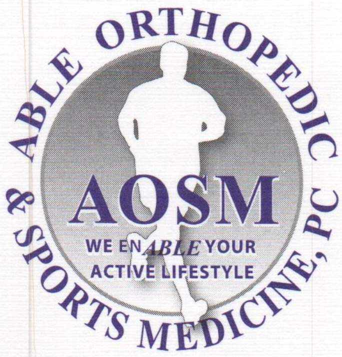

Able Orthopedic & Sports Medicine, PC
www.ableorthopedic.com

76-55 Austin Street
Forest Hills, NY 11375

Tel: 718-897-2228
Fax: 718-897-2251

Member Authorization Form for a Designated Representative to Appeal a Determination

Date: ______________________________

Member Name: ______________________________

Patient Name: ______________________________

Member #: ______________________________

I hereby authorize Able Orthopedic & Sports Medicine to appeal the determination concerning _____________________ (date of service) on my behalf, as my Designated Representative, and as part of the appeal, I authorize ______________________________________ (insurance company) in its decision letter and in connection with the processing of my appeal, to communicate with my Designated Representative in all aspects of the appeal. I understand this information is privileged and confidential and will only be released as specified in this authorization, or as required pr permitted by law.

____
Signature of Member or Legal Guardian/Representative

____
Signature of Witness

____
Name of Witness/Title