

**Member Authorization Form for a Designated Representative to appeal a Determination.**

Date: \_\_\_\_\_

Member Name: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Member #: \_\_\_\_\_

I hereby authorize Pediatric Surgical Associates 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 or permitted by law.

\_\_\_\_\_  
Signature of Member or Legal Guardian/Representative

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Name of Witness/Title