Patient Consent for Provider to File and Appeal

Provider Information

Provider name: ______________________________ NPI: ______________

Group name: ____________________________ Phone: ______________

Mailing address: ____

City: ______________________ State: ________ Zip: ______________

Description of service(s) that may be appealed:	Date(s) service was provided:

You can have this information in other languages and formats at no charge to you. You can also have this interpreted over the phone in any language. Call Member Services at **1-888-756-0004**. For TTY, call **1-866-428-7588**.

Quý vị có thể có thông tin này bằng các ngôn ngữ và định dạng khác miễn phí. Quý vị cũng có thể có thông tin này thông dịch ra bất kỳ ngôn ngữ nào qua điện thoại. Xin gọi Dịch vụ Thành viên số **1-888-756-0004**.

Puede obtener esta información en otros idiomas y formatos sin costo. También se le puede interpretar esto por teléfono en cualquier idioma. Llame a Servicios al Miembro al **1-888-756-0004**.

AmeriHealth Caritas Louisiana

www.amerihealthcaritasla.com

ACLA-1322-107

Member Information and Consent

I agree to allow the provider listed above to file an apeal for me with AmeriHealth Caritas Louisiana in there is a question about coverage for the services listed. I have read this consent of have it read to me and it has been explained to my satisfaction. I understand the information in the consent form and give my consent to this provider to file an appeal for me.

Provider name *(print)*: ______________________________ Date of birth: ______________

Member ID: ____

Mailing address: ____

City: ______________________ State: __________ Zip: ______________

Patient signature: ______________________________ Date: ______________

Consent from a Designated Representative

The patient listed above is unable to sign this consent form because of the reason*(s)* listed below and I consent for the patients:

Representative name *(print)*: ______________________________________

Representative to patient: ____

Representative signature: ______________________________ Date: ______________

Witnees name: ____

Signature: ______________________________ Date: ______________

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