# Designation of Authorized Representative to Appeal

I, _____ (member name), authorize the individual or entity listed below to act on my behalf as my authorized representative to pursue an appeal of the specific claim(s) noted below. I understand that personal medical information related to my appeal may be disclosed to my appointed authorized representative.

**This designation is limited to the specific claim(s) listed below.**

**Member Information**

Name:_____ Date of Birth:_____

Mailing Address:_____

Member ID Number:_____ Telephone Number:_____

**Authorized Representative Information**

Name:_____

Mailing Address:_____

Telephone Number:_____ Fax Number:_____

Relationship to Member:_____

Provider Number (if applicable):_____

**Claim Information**

Claim Number:_____

Date of Service:_____

Total Charge(s):_____

Provider:_____

Additional Claim Number (if applicable):_____

Additional Claim Number (if applicable):_____

**Member Signature:**_____ **Date:**_____

Please complete, sign and submit this form to:
BlueChoice HealthPlan of South Carolina, Inc.
Attn: Appeal (AX-720)
P.O. Box 6170
Columbia, SC 29260
Fax Number: 800-610-5685