&216(17)25 3529,'(5 72),/($1 $33($/ 21 3$7,(17 0(0%(5¶6 %(+$/)

3529,'(5 ,1)250$7,21

Provider Name:	Provider NPI:
Group Name:	Phone Number:
Address, City, State and ZIP:	

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0(0%(5 ,1)250$7,21 $1' &216(17 I give consent for the provider listed above to file an appeal on my behalf with CareSource. This will be an appeal of the denial of health care services issued by CareSource that is described above. I have read this consent or have had it read to me and it has been explained to my satisfaction.

Member Name:	Member ID:	Date of Birth:
Address, City, State and ZIP:		Phone Number:
Member Signature:		Date:

&216(17)520 $ 5(35(6(17$7,9(The member listed above is unable to sign this consent form because of the reason(s) listed below, and I consent for the member: ______________________________

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If signed by someone other than the member/minor member's parent, you must provide a copy of the power of attorney or court document showing authority to act on the member's behalf, if you have not already done so. Please complete the following fields:

Representative Name:	Representative Phone Number:	Relationship to Member:
Representative Signature:		Date:
Witness Name:	Witness Signature:	Date: