

SHARRON A. MACKEY, MHS, MPA  
CHIEF EXECUTIVE OFFICER

DENNIS HSIEH, MD, JD  
Chief Medical Officer



## MEMBER SERVICES

595 Center Avenue, Suite 100  
Martinez, California 94553

Main Number: 925-313-6000  
Member Call Center: 877-661-6230 Option #2  
Provider Call Center: 877-800-7423  
Fax: 925-313-6047

www.contracostahealthplan.org

Se Habla Español

### Member Consent for Provider to File an Appeal on my Behalf with Health Insurance Plan

I, \_\_\_\_\_ understand that in this consent form, I  
(Name of member)

grant

my consent to the following provider \_\_\_\_\_ to file an appeal  
(Name of provider)

on my behalf.

#### Member Information:

<b>Print Member Name</b>	<b>Member date of birth</b>	<b>Health Plan ID #</b>
<b>Member address</b>		

#### Provider Information:

<b>Print Provider Name</b>	<b>Provider Plan ID No.</b>	<b>Provider Phone No.</b>
<b>Provider address</b>		<b>Date(s) of Service</b>
<b>Description of services that are being appealed</b>		
<b>Description of services that are being appealed</b>		

I agree to allow the above health care provider to file an appeal on my behalf, with Contra Costa Health Plan, if there is a question about coverage for the service(s) listed above.



I understand that:

- If I consent, I will not be able to file my own appeal concerning these same services, nor will any representative I appoint, unless this consent is rescinded in writing.
- I have a right to rescind this consent at any time. My legal representative has the right to rescind this consent at any time.
- This consent shall be automatically rescinded if my health care provider does not file an appeal or discontinues my appeal.
- I have read this consent or have had it read to me, and it has been explained to my satisfaction.

<b>Member signature</b>	<b>Date</b>
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\*The above-named member is unable to sign this consent form because of the following reason: *(only to be completed if member is unable to provide signature)*

<b>Reason Member is unable to provide a signature</b>
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I consent for the above-named member:

<b>Print Representative Name:</b>	<b>Representative Signature</b>	<b>Date</b>
<b>Print Witness Name:</b>	<b>Witness Signature</b>	<b>Date</b>

Return the completed authorization form in one of the following ways:

**Mail:**

Member Appeals Department  
595 Center Avenue, Ste 100  
Martinez, CA 94553

**FAX:**

(925) 313-6047

