KAISER PERMANENTE®
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

Attachment 2
Authorized Representative for Member Appeal Form

Authorized Representative for Member Appeal Form

Submit this form to: Provide one or all options to receive this form.

Kaiser Permanente
Attn: Member Services
Nine Piedmont Center
3495 Piedmont Road, NE
Atlanta, GA 30305-1736
Fax: 404-949-5001

An authorized representative is someone who has legal permission to act on your behalf with Kaiser Permanente, like a family member, a friend, a provider, or a lawyer.

Member Name (First Name, Middle Name, Last Name)

_____

Member Home Address (Address, City, State, Zip Code)

_____

Member Date of Birth _____/_____/_____

Member ID Number _____

Member Phone Number _____

Service(s) Under Appeal: _____

Name & Credentials of Representative Appealing for the Enrollee

_____

Provider or Representative Address

_____

Provider or Representative Phone Number _____

Kaiser Permanente has denied the services listed above. By signing below, you authorize the provider or representative to appeal this denial for you.

Member Name Printed _____

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Member Signature _____ Date _____

This information in this letter is confidential and contains protected health information. The information should be treated as confidential, private, and protected in a manner consistent with the Social Security Act and the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations. This information may only be further disclosed in accordance with federal regulations found in 42 CFR 480.107-108. Authorized representative as defined in COMAR 10.01.04.12.