AmeriHealth Caritas Next

A product of AmeriHealth Caritas Indiana, Inc.

Member Consent for Provider/ Representative to File an Appeal

Note: The member or their legally authorized representative must sign this document.

I authorize AmeriHealth Caritas Next to release any of my protected health information (PHI) to my representative named below for the purpose of resolving my appeal. I understand that this information may contain sensitive data, including data related to, but not limited to, the following:

- Information that may be related to substance use disorders
- Reproductive health care
- Treatment of sexually transmitted or communicable diseases
- HIV/AIDS
- Mental and behavioral health (except psychotherapy notes)
- Genetic testing

In completing this authorization form, I understand that the person(s) whom I have given permission to receive my PHI may not be subject to federal health information privacy laws, that they may disclose my information, and that it may no longer be protected by federal health information privacy laws.

I understand the following:

- This authorization may be revoked at any time by mailing a written notice to AmeriHealth Caritas Next.
- Revoking this authorization will not affect any action that AmeriHealth Caritas Next has taken prior to receiving my notice of revocation.
- AmeriHealth Caritas Next will not condition the provision of my health plan benefits because of this authorization.
- This authorization will expire upon resolution of this appeal.

Please note: By completing and submitting this form, you are granting authority to a third party (such as a provider or other legally authorized representative) to file an appeal on your behalf. You are aware that you or your authorized representative may submit additional information to be included with the appeal or external review. This form is not intended to be your actual appeal request. Please ensure that your appeal request is submitted by your third-party representative if it has not already been submitted to us.

Attention:

This authorization will not be accepted if it is dated prior to the date of the disputed adverse benefit determination. This authorization will also not be accepted if you or your legal authorized representative's signature is not on this document.

All fields are required including member signature and date.

Provider/representative information		
Provider/ representative name:		NPI*:
Group name*:		Phone:
Address:		
City:	State:	ZIP code:
Description of action that may be appealed:		

*These fields apply to providers.

Member information and consent	
I agree to allow the provider listed above to file an appeal for me with AmeriHealth Caritas Next. This will be an appeal of the action taken by AmeriHealth Caritas Next that is described above. I have read this consent or have had 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. This form shall be valid for one year from the date of my* signature. I understand that I may revoke this consent at any time.	
Member name:	Date of birth:
Address:	Phone:
Member signature:*	Date:**
* This must be signed by the member or legally authorized representative. **Consent cannot be dated before the date(s) of the service(s) in question. **Remember:** Attach legal documentation.	

Consent from provider/representative	
☐ The member listed above is unable to sign this consent form because of the reason(s) listed below. I am authorized to consent on behalf of the member, and I hereby give my consent:	
Provider/ representative name:	Relationship to member:
Provider/ representative signature:	Date: