MEMBER CONSENT FORM
For provider to act as an authorized representative

Member Name _____

Identification Number _____

Date of Birth: _____

Briefly describe the service and date(s) the Authorized Representative will be acting on your behalf and reason for appeal:

I give consent for my provider _____
to submit a clinical appeal, on my behalf, and to act as an authorized representative in the appeal process.

Member Signature (Authorized Representative, if applicable) Date:

Medicaid appeal rules require that Cook Children's Health Plan have a written appeal request on file. This consent form must be signed by the member (or an authorized representative) in order for a provider to appeal on their behalf. Once this has been signed, please have your provider fax or mail this form with an appeal letter to:

Cook Children's Health Plan

Attn: Care Management Denials & Appeals Department

PO Box 2488

Fort Worth, Texas 76113-2488

Toll-free phone number: 888-243-3312

Fax Number: 682-885-8402