



Designation of Authorized Representative to Appeal

I, _____ (member name), authorize the individual or entity listed below to act on my behalf as my authorized representative to pursue an appeal of the specific claim(s) noted below. I understand that personal medical information related to my appeal may be disclosed to my appointed authorized representative.

This designation is limited to the specific claim(s) listed below.

Member Information

Name: _____ Date of Birth: _____

Mailing Address: _____

Member ID Number: _____ Telephone Number: _____

Authorized Representative Information

Name: _____

Mailing Address: _____

Telephone Number: _____ Fax Number: _____

Relationship to Member: _____

Provider Number (if applicable): _____

Claim Information

Claim Number: _____

Date of Service: _____

Total Charge(s): _____

Provider: _____

Additional Claim Number (if applicable): _____

Additional Claim Number (if applicable): _____

Member Signature: _____ **Date:** _____

Please complete, sign, and submit this form to:

Planned Administrators, Inc.
Attn: HIPAA Privacy Coordinator
P.O. Box 6927
Columbia, SC 29260