Member Consent for Provider or Representative to File an Appeal

Mail to: P.O. Box 45180, Salt Lake City, UT 84120
Fax to: 801-281-6121
Phone: 801-587-6480 opt 1
Email: uuhp@hsc.utah.edu

Please print all information, except signature

Provider Information:

Provider Name: ___________________________________ NPI #: _________________________________

Vendor/Group Name: ______________________________ Phone #:_______________________________

Address (city, state, zip): ____

____

Description of action you want to appeal (you may attach additional information):

Member Information and Consent: I give consent for my provider to appeal for me, to the University of Utah Health Plan (UUHP). The appeal will be for the action taken by UUHP, noted above. I have read this consent or have had it read to me. The reason for the appeal was explained to me. I am aware of the information in the consent form.

Member Name: _______________________ Member ID #: ________________ Date of Birth: __________

Address: ____ Phone #: _____________

Member Signature: ____ Date*: ______________

*Consent should not be dated before the date(s) of service(s) that are being appealed.

Consent from a Designated Representative:

The member is unable to sign the consent form because of ____

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I am authorized to give consent on behalf of the member.

Representative Name: ______________________________ Relationship to member: __________________

Representative Signature: __________________________________ Date: ___________________

Witness Name_____________________ Signature______________________ Date: ___________________