Community HealthChoices | AmeriHealth Caritas Pennsylvania

Coverage by AmeriHealth First.

Patient Consent for My Provider to File a Grievance on my Behalf with my Health Insurance Plan

Provider Name:	Provider Plan ID Number:
Provider Address:	
Description of services that may be appealed:	Date(s) services were provided:

I agree to allow this health care provider to file a grievance on my behalf with the following health plan if there is a question about coverage for the services listed below.

I understand that:

1. If I consent, I will not be able to file my own grievance concerning these same services, nor will any representative I appoint, unless this consent is rescinded in writing.
2. I have a right to rescind this consent at any time. My legal representative has the right to rescind this consent at any time.
3. This consent shall be automatically rescinded if my health care provider does not file a grievance, or stops grieving my case.

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 grant my consent to this provider to file a grievance on my behalf.

Print Patient Name:	Patient Date of Birth:	Health Insurance Company:
Patient Address:		Patient Insurance ID Number:
Patient Signature:		Signature Date:

The above named enrollee is unable to sign this consent form because of the following reasons and I consent for the above named enrollee:	
Print Representative Name:	Relationship to the Patient:
Representative Signature:	Signature Date:

Print Witness Name:	Witness Signature:	Signature Date: