



Louisiana

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

Member Name		Date of Birth	
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Mailing Address

Member ID Number		Telephone Number	
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Authorized Representative Information

Name			
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Mailing Address

Telephone Number		Fax Number	
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Relationship to Member	Provider Number (if applicable)
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Claim Information

Claim Number	
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Date of Service

Total Charge(s)	
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Provider

Additional Claim Number (if applicable)	
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Additional Claim Number
(if applicable)

Member Signature: _____

Date: _____

Mail your written request for appeal with the above information to: Columbia Service Center
P.O. Box 100121
Columbia, SC 29202