



**IOWA
Patient Consent for Provider to File an Appeal**

Provider Information

Provider name: _____ NPI#: _____ Group name: _____

Phone: _____ Address: _____

Description of service(s) that may be appealed:	Date(s) service was provided:
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Member Information and Consent

I agree to allow the provider listed above to file an appeal on my behalf with AmeriHealth Caritas Iowa. The provider will file if there is a question about coverage for the services listed. I have read this consent or it has been read to me. I understand the information in the consent form. I give my consent to this provider to file an appeal for me.

Patient name (print): _____

Date of Birth: _____ Member ID #: _____

Address: _____ Phone: _____

Patient signature: _____ Date: _____

You can have this information in other languages and formats at no charge to you. You can also have this interpreted over the phone in any language. Call Member Services 24 hours a day, 7 days a week at 1-855-332-2440. For TTY, call 1-844-214-2471.

Usted puede tener esta información en otros idiomas y formatos sin costo alguno para usted. También puede tener esto interpretado por teléfono en cualquier idioma. Llame a Servicios al Miembro al 1-855-332-2440 las 24 horas del día, los 7 días de la semana. Para TTY, llame al 1-844-214-2471.



Consent from a Designated Representative

The patient listed above is unable to sign this consent form because of the reason(s) listed below and I consent for the patient:

Representative name (print): _____

Relationship to patient* _____

Representative signature: _____ Date: _____

Witness name: _____

Signature: _____ Date: _____

***Must be a Parent, Guardian or Authorized Representative in order to sign this consent form.**

Return To:

**AmeriHealth Caritas Iowa
Attention: Request for Criteria
Member Appeals Department
601 Locust St., Suite 900
Des Moines, IA 50309**

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