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:

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: _____

AmeriHealth Caritas Iowa
P.O. Box 1516
Des Moines, Iowa 50305

www.amerihealthcaritasia.com

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

AmeriHealth Caritas Iowa
P.O. Box 1516
Des Moines, Iowa 50305

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