



# Member Consent Form

To allow a Provider to Appeal on a Member's behalf.

**Member Name:** \_\_\_\_\_

**Member ID:** \_\_\_\_\_

**Member Date of Birth:** \_\_\_\_\_

I agree that my Provider \_\_\_\_\_ can appeal the denial made by Community Health Plan of Washington for the following service.

Service: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Member Signature (Parent or Legal Guardian if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Parent or Legal Guardian (if applicable)

(Please attach legal documentation if you are the Power of Attorney)

**Please mail or fax this signed form**

**Community Health Plan of Washington  
1111 3rd Ave. Suite 400  
Seattle, WA 98101  
Fax 206-613-8984**