COMMUNITY HEALTH PLAN of Washington™

Member Consent Form

To allow a Provider or Authorized Representative to Appeal on a Member's behalf.
Completion of all fields is required.

Member Name: _____

Member #: _____

Member Date of Birth: _____

Denied Certification #: _____

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

Service: _____ Date: _____
(amount and name of service, medication, equipment, etc.) (planned date of service)

_____ _____
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