COMMUNITY HEALTH PLAN of Washington™

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