PROVIDER INFORMATION

PROVIDER NAME: ____
GROUP: ______________________________ NPI ________________
ADDRESS ________________________________ PHONE ____________
Description of action to appeal:
____
____
____
____

MEMBER INFORMATION AND CONSENT

I agree to allow the provider listed above to file an appeal on my behalf with Maryland Physicians Care. This will be an appeal of the action taken by Maryland Physicians Care that is described above. I have read this consent form or have had it read to me and it has been explained to my satisfaction. I understand this information on the consent form and give my consent to this provider to file an appeal for me.

MEMBER NAME (print) ____
DATE OF BIRTH ________________ MEMBER ID# ____________________
ADDRESS____
PHONE _________________________ EMAIL _________________________
MEMBER SIGNATURE _________________________________ DATE ________

CONSENT FROM A DESIGNATED REPRESENTATIVE OR OFFICE STAFF WITNESSES

The member listed above is unable to sign this consent form because of the reason(s) listed below.
____
____

☐ I am authorized to consent on behalf of the member and I hereby give my consent:

REPRESENTATIVE NAME (print) __________________________________
RELATIONSHIP TO MEMBER _______________________________________
REPRESENTATIVE SIGNATURE ___________________________ DATE ________

☐ I have been given verbal consent by the member either over the phone or in person (at least 2 witnesses):

OFFICE STAFF 1 NAME (print) __________________________________
OFFICE STAFF 1 SIGNATURE ____________________________ DATE________

OFFICE STAFF 2 NAME (print) __________________________________
OFFICE STAFF 2 SIGNATURE ____________________________ DATE ________