AmeriHealth Caritas Next

A product of AmeriHealth Caritas VIP Next, Inc.

Member Consent for Provider to File an Appeal

Note: The member or their authorized representative must sign this document.

Provider information

Provider name:		NPI:
Group name:		Phone:
Address:		
City:	State:	ZIP code:
Description of action that may be appealed:		

Member information and consent

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

Member name:	Date of birth:
Address:	Phone:
Member signature:*	Date:**

* Must be signed by the member.
**Consent cannot be dated before the date(s) of the service(s) in question.

Consent from a designated representative

☐ 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:	Relationship to member:
Representative signature:	Date:

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Provider Appeals: Phone: **1-866-577-0833** | Fax: **1-833-337-7329**