Avera Health Plans

Authorization to Appoint my Provider for Appeal(s)

Member Name: _____
Member Address: _____
Phone Number: _____

1. Authorization to Release Medical and Insurance Information

I,_____, authorize the release of any medical and insurance information necessary to process claims for services provided by_____. I authorize_____to pursue all necessary appeals of full or partial payment on my behalf with my health insurance company in relation to services provided.

_____ _____
Signature of Patient/Member Date

2. Authorization to Appoint my Provider

I,_____, appoint_____to act on my behalf in connection with any appeal regarding claims and coverage or benefits. I authorize my representative to receive any and all information that is provided to me, and to act for me and for my covered spouse or dependent, if named above as the patient, in providing any information to the health insurance company that relates to any claim for coverage or benefits under this plan.

_____ _____
Signature of Patient/Member Date

3. Provider Acceptance of Appointment

I,_____, hereby accept the above responsibilities.

Representative's Full Address: _____
Representative's Phone Number: _____
Representative's Fax Number: _____

_____ _____
Signature of Provider/Authorized Representative Date

Final Step: Please fax the completed form to **1 (800) 269-8561** or mail to:
Avera Health Plans, Attn: Complaint and Appeals Coordinator
5300 S. Broadband Ln.
Sioux Falls, SD 57108-2221

If you have any questions, please call our Service Center at (605) 322-4545, 8 a.m. to 5 p.m., Monday through Friday.