

Date	
Name Address City, State, Zip	
Patient: Date of Birth: Date(s) of Service: Provider: Reference Inquiry: Regarding:	
I have given my permission forto repr regarding the above-referenced denial for the following services	resent me, and act on my behalf
I authorize Blue Cross and Blue Shield of North Carolina (BCBSN protected health information (PHI) to my representative named about my appeal.	
I understand that I may revoke this authorization at any time by ma BCBSNC at the address below. I understand that revoking this aut action that BCBSNC has taken prior to receiving my notice of revo	horization will not affect any
I further understand that BCBSNC will not condition the provision because of this authorization.	of my health plan benefits
I further understand that the person(s) that I have given permission subject to federal health information privacy laws and that they ma it may no longer be protected by federal health information privacy	y disclose my information and
This authorization will expire upon resolution of this appeal.	
Thank you.	
Member Signature Date	