Member Approval for Appeal Delegation

Date Form Sent To Provider: _____

I designate my provider, _____, to act on my behalf regarding the following member appeal issue:

_____

_____

_____.

I understand that by authorizing my provider to appeal this issue on my behalf, I give up my right to appeal this same issue myself.

Member Name (Print) Member ID Number

Member Name (Signature) Date

Return this completed form within 30 days to: MVP Health Care Member Appeals Department

625 State Street, Schenectady, New York 12305

or fax to 518-386-7600