INSTIL® HEALTH

DESIGNATION OF AUTHORIZED REPRESENTATIVE TO APPEAL

I, _____ (member name), authorize the individual or entity listed below to act on my behalf as my authorized representative to pursue an appeal of the specific claim(s) noted below. I understand that personal medical information related to my appeal may be disclosed to my appointed authorized representative.

This designation is limited to the specific claim(s) listed below.

Member Information

Member Name		Date of Birth	
Mailing Address			
Member ID Number		Telephone Number	

Authorized Representative Information

Name			
Mailing Address			
Telephone Number		Fax Number	
Relationship to Member		Provider Number (if applicable)	

Claim Information

Claim Number	
Date of Service	
Total Charge(s)	
Provider	
Additional Claim Number (if applicable)	
Additional Claim Number (if applicable)	

Member Signature: _____ **Date:** _____

Mail your written request for appeal with the above information to:

InStil Health
PO Box 100324
Columbia, SC 29202-3324
Mail Code: AX-F37