Appointment of Authorized Representative

Illinois Department of Insurance

This form is to be completed when someone other than the patient, parent, guardian or other legal representative is representing the patient in this appeal. Health Care Providers must have this form completed in order to act as an Authorized Representative. This authorization may be revoked at any time with written notification to the Department of Insurance.

Covered Person/Patient

first name _____ last name _____

address _____

city _____ state _____ zip _____

daytime phone _____ email _____

Person I Authorize to Pursue My Appeal

first name _____ last name _____

address _____

city _____ state _____ zip _____

daytime phone _____ email _____

Signature for Authorization

I hereby authorize the above identified person to pursue an appeal on my behalf.

_____ _____

signature of covered person/patient or guardian
if under 18, signature of parent

date

Return this form to:

Illinois Department of Insurance
Office of consumer Health Insurance
External Review Request
320 W. Washington Street
Springfield, IL 62767
877-850-4740 toll free phone
217-557-8495 fax
Insurance.Illinois.gov/ExternalReview