APPOINTMENT OF AUTHORIZED REPRESENTATIVE FORM

Member Name _____ **Member ID Number** _____

I, _____ , appoint Stephanie Stuart
Name of Member — Name of Authorized Representative

to act on behalf of _____
Name of Member

in connection with any claim for coverage or benefits identified in case # _____ including receipt of any approval(s) or authorization(s) that are required before medical service(s). I authorize my representative to receive any and all information related to this case that is provided to me, and to act for me and for my minor dependent, if named above, in providing any information to the group health plan in relation to the disputed claims, approvals, or authorizations. This document is not intended to authorize access to any personal health information unrelated to the disputed claims, approvals, or authorizations.

Signature of Member _____ **Date** _____

Address: _____ Telephone Number: _____

_____

_____

I, Stephanie Stuart , hereby accept the above appointment.
Name of Authorized Representative

I am a/an A/R Analyst
Relationship to member

Stephanie Stuart
Signature of Authorized Representative **Date**

Address: Arapahoe Gastroenterology Anesthesia Assoc Telephone Number: 888-337-3509

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