Consent for Provider to File an Appeal on a Member's Behalf

Member information

First Name:	Last Name:
Member ID:	Member Date of Birth:
Address, City, State, and ZIP:	

Provider information

Provider Name:	Provider UPMC Identification Number:
Address, City, State, and ZIP:	
Phone Number:	

Policyholder information (if different from member)

Policyholder Name:	Policy Number:
Address, City, State, and ZIP:	

Please provide a description of the specific service(s) for which coverage was provided or denied:

UPMC Health Plan

Please read the following statements carefully before signing.

I understand and acknowledge that by signing below:

- I consent to the provider named in this form filing a grievance on my behalf regarding the service(s) listed and I understand that my consent is not required as a condition of providing the treatment(s) or service(s) listed.
- I may not submit a grievance concerning the services listed in this consent form unless I rescind this consent in writing. I have the right to rescind this consent at any time during the grievance process by sending a letter to UPMC Health Plan, Attn: Complaints and Grievances, PO Box 2939, Pittsburgh, PA 15230-2939.
- The provider named in this form must notify me if the provider decides not to file the grievance. This consent shall automatically be rescinded if the named provider fails to file a grievance or fails to continue to pursue the grievance through the grievance review process.
- I have read this consent form and have had it explained to my satisfaction. I understand the information in this consent form.

Signature of Member or Member's Representative:	Date:

Signature of Witness:	Date:

If the member is a minor or legally incompetent, please provide the name and relationship to the member of the person who is giving consent:

Name:	Relationship:
Address, City, State, and ZIP:	

UPMC Health Plan

U.S. Steel Tower, 600 Grant Street
Pittsburgh, PA 15219

www.upmchealthplan.com

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