Kansas City

2301 Main Street Kansas City, MO 64108 • (816) 395-2222 • BlueKC.com

MEMBER AUTHORIZATION FORM
Allowing a provider to appeal on behalf of the member

Date

Provider Name
Address
Address

Patient:
Date of Birth:
Member ID:

I authorize for my provider, ______________________________, to appeal, on my behalf, the denial made by Blue Cross and Blue Shield of Kansas City (Blue KC) dated ______________.

I authorize Blue Cross and Blue Shield of Kansas City (Blue KC) to release any of my Protected Health Information (PHI) to my representative named above for the purpose of resolving my appeal.

I understand that I may revoke this authorization at any time by mailing a written notice to Blue KC at the address listed below. I understand that revoking this authorization will not affect any action that Blue KC has taken prior to receiving my notice of revocation. I further understand that this authorization is not required for Blue KC to process benefits according to my contract.

This authorization will expire on year after the date indicated below.

Thank you,

_________________________________ _______________________
Member Signature Date

This authorization form must be signed by the member (or an authorized representative) in order for a provider to appeal on their behalf. Once this has been signed, please have your provider fax or mail this form with an appeal letter to:

Blue KC
Attn: Appeals
PO Box 417005
Kansas City, MO 64179-9773
Fax (816) 278-1920

Blue Cross and Blue Shield of Kansas City is an independent licensee of the Blue Cross and Blue Shield Association.