Authorization for Appeals

Date: _____

Patient Name: _____Social Security #_____

Date of Birth: _____ Insurance Co. Name: _____

_____

I authorize the provider(s) listed below and his billing staff to appeal any claim(s) for service(s) rendered on my behalf. I understand that there will be circumstances that will prevent the provider(s) of service from appealing the claim(s) in question and that it will be my responsibility to appeal with the insurance company directly. This authorization will be valid from the date of signature. If I decide to revoke this authorization the provider of service will be notified in writing.

_____ _____

Policy holders Signature Policy holders Social Security #

_____ _____

Policy holders Date of birth Date

Providers: **Providers: DR's. C.Smith; M.Oz; Y.Naka; M.Argenziano; H. Spotnitz; H.Takayama;Isaac George, M.Borger, Syed T. Raza, Barry Esrig, Koji Takeda,PA's-Thomas Cosola, R-PA; M.Flannery, FNP; R.Te-Frey, FNP; J.Murphy; M.Finelle Torres, M. Tiburcio; Dana Reed ACNP, M.Duffy, K.Ross, M. Powers, M. Tsukashita**