# Authorized Representative for Member Appeal Form

**Submit this form to:**

Maryland Physicians Care
P.O. Box 893 Portland, ME 04104
Fax: 866-831-0790

An authorized representative is someone who has legal permission to act on your behalf with Maryland Physicians Care like a family member, a friend, a provider, or a lawyer.

**Member Name (First Name, Middle Name, Last Name)**

_____

**Member Home Address (Address, City, State, Zip Code)**

_____

**Member Date of Birth** _____/_____/_____

**Member ID Number** _____

**Member Phone Number** _____

**Service(s) Under Appeal:** _____

**Name & Credentials of Representative Appealing for the Enrollee**

_____

**Provider or Representative Address** _____

**Provider or Representative Phone Number** _____

Maryland Physicians Care has denied the services listed above. By signing below, you authorize the provider or representative to appeal this denial for you.

**Member Name Printed** _____

**Member Signature** _____ **Date** _____

This information in this letter is confidential and contains protected health information. The information should be treated as confidential, private, and protected in a manner consistent with the Social Security Act and the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations. This information may only be further disclosed in accordance with federal regulations found in 42 CFR 480.107-108. Authorized representative as defined in COMAR 10.01.04.12.

The MPC Mission: A COMMITMENT TO ABOVE & BEYOND