BOSTON MEDICAL CENTER
HEALTHNet PLAN

APPEAL REPRESENTATIVE AUTHORIZATION FORM

Member Name: ____________________ **Member ID Card #:** ______________________

Date of Birth: _____________________ **Address:** __________________________________

City: _____________________________ **State:** MA **Zip Code:** _________________

Phone #: __________________________

I hereby authorize the following person to act as my Appeal Representative for the above referenced Internal Appeal. I understand that this person may be given health or payment information related to the above referenced Internal Appeal. Boston Medical Center HealthNet Plan will act on this information until I revoke or amend this authorization in writing. This authorization expires on the date the Plan sends out the Final Internal Appeal decision notice related to this matter.

Appeal Representative Name: ____

Phone #: ____________________________________

Member/Legal Representative Signature: ______________________________________

Date: ______________________________________

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1-888-566-0010 (English and other languages)
711 (TTY/TDD)