# 1199SEIU Benefit Funds

Appeals Department, PO Box 646, New York, NY 10108-0646 • (646) 473-9200 • Outside NYC: (800) 575-7771 • www.1199SEIUBenefits.org

## BENEFIT FUND APPEAL REPRESENTATION AUTHORIZATION FORM

**(Please print clearly in blue or black ink, or complete online.)**

PATIENT'S NAME

PROVIDER'S NAME

PROVIDER'S ADDRESS

CITY

STATE

ZIP CODE

PATIENT'S DATE OF BIRTH (MM/DD/YYYY)

Patient's relationship to member (choose one): ☐ Self ☐ Spouse ☐ Child

MEMBER'S NAME ***(if not the patient)***

MEMBER ID #

CLAIM/AUTHORIZATION #

***This section is to be completed by the patient.***
***The parent/legal guardian can sign on behalf of his or her child who is under 18 years of age.***

I, _____ (PATIENT'S NAME), do hereby authorize _____ (REPRESENTATIVE'S NAME), to be my Authorized Representative for the purpose of appealing the denial of benefits for the above-referenced claim. Please be advised that this authorization is valid for the above-referenced claim only; it does not allow the Authorized Representative to: (i) appeal unrelated claims; or (ii) appoint a third-party representative; or (iii) exercise your rights as a beneficiary.

**X** _____

PATIENT'S SIGNATURE OR PARENT'S/LEGAL GUARDIAN'S SIGNATURE

DATE (MM/DD/YYYY)

Please print out and sign. Return the completed authorization form, copies of the Fund's correspondence and any additional supporting documentation to:

**1199SEIU Benefit Funds**
**Appeals Department**
**PO Box 646**
**New York, NY 10108-0646**