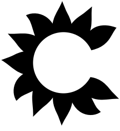


# Member Consent Form

To allow a Provider to Appeal on a Member's behalf.

**Member Name:** ______________________________

**Member ID:** ________________

**Member Date of Birth:** __________

I agree that my Provider ____________________ can appeal the denial made by Community Health Plan of Washington for the following service.

Service: ____________________________ Date: ______________

______________________________ ______________

Member Signature (Parent or Legal Guardian if applicable) Date

______________________________

Print Name of Parent or Legal Guardian (if applicable)

(Please attach legal documentation if you are the Power of Attorney)

**Please mail or fax this signed form**

**Community Health Plan of Washington**
**1111 3rd Ave. Suite 400**
**Seattle, WA 98101**
**Fax 206-613-8984**