Fairfield Office – 4665 Business Center Drive, Fairfield, CA 94534
Redding Office – 2525 Airpark Drive, Redding, CA 96001

MEMBER AUTHORIZATION FOR PROVIDER APPEAL

*[*Date*]*

Hospital/Clinic/Pharmacy Name
Treating Provider Name
Address
City, State ZIP

Member Name
Address
City, State, Zip

Re: (Insert Member Name) Appeal Authorization
Member CIN:_____
TAR #:_____
RAF#:_____

Dear Partnership HealthPlan of California (Partnership):

I would like to file an Appeal regarding the Notice of Action (NOA) received for: _____

_____

_____

_____

I,_____, authorize my Physician,_____, to submit this Appeal on my behalf.

I understand that if I have any questions regarding this Appeal, I can contact Partnership at the number provided within the Your Rights Notice attached.

_____
Print Member Name

_____
Print Physician Name

_____
Member Signature

_____
Physician Signature

_____
Date:

_____
Date:

Mailed On: