AmeriHealth Caritas Louisiana

www.amerihealthcaritasla.com

# Patient Consent for Provider to File and Appeal

**Provider information**

Provider name: NPI:

Group name: Phone number:

Mailing address:

City: State: ZIP code:

| Description of service(s) that may be appealed: | Date(s) service was provided: |
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AmeriHealth Caritas Louisiana complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

You can have this information in other languages and formats at no charge to you. You can also have this interpreted over the phone in any language. Call Member Services 24 hours a day, seven days a week, at **1-888-756-0004**. For TTY, call **1-866-428-7588**.

Qúy vị có thể có thông tin này bằng các ngôn ngữ và định dạng khác miễn phí. Quý vị cũng có thể có thông tin này thông dịch ra bất kỳ ngôn ngữ nào qua điện thoại. Xin gọi Dịch vụ Thành viên phục vụ 24 giờ/ngày, 7 ngày/tuần theo số **1-888-756-0004**. Đối với người sử dụng TTY, xin gọi số **1-866-428-7588**.

Usted puede tener esta información en otros idiomas y formatos sin costo alguno para usted. También puede tener esto interpretado por teléfono en cualquier idioma. Llame a Servicios al Miembro al **1-888-756-0004** las 24 horas del día, los siete días de la semana. Para TTY, llame al **1-866-428-7588**.

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# Member Information and Consent

**www.amerihealthcaritasla.com**

I agree to allow the provider listed above to file an appeal for me with AmeriHealth Caritas Louisiana if there is a question about coverage for the services listed. I have read this consent or have had it read to me and it has been explained to my satisfaction. I understand the information in the consent form and give my consent to this provider to file an appeal for me.

Provider name (print):

Date of birth: Member ID:

Mailing address:

City: State: ZIP code:

Patient signature: Date:

Consent from a designated representative

The patient listed above is unable to sign this consent form because of the reason(s) listed below and I consent for the patients:

Reason(s) unable to sign:

Representative name (print):

Representative to patient:

Representative signature: Date:

Witness name:

Signature: Date:

Mail to:
AmeriHealth Caritas Louisiana
P.O. Box 7328
London, KY 40742-7344

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