



**APPOINTMENT OF REPRESENTATIVE STATEMENT**

\_\_\_\_\_  
Beneficiary Name

\_\_\_\_\_  
Member ID Number

\_\_\_\_\_  
Provider

\_\_\_\_\_  
Dates of Service

I hereby swear that I am the above-mentioned beneficiary or an authorized representative of the above-mentioned beneficiary. I do hereby appoint the swearing individual \_\_\_\_\_ to act as my representative in requesting reconsideration from AvMed Health Plans or its designee regarding the services, which the health plan has denied payment or authorization.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date