# Appointment of Authorized Representative

## Illinois Department of Insurance

This form is to be completed when someone other than the patient, parent, guardian or other legal representative is representing the patient in this appeal. Health Care Providers must have this form completed in order to act as an Authorized Representative. This authorization may be revoked at any time with written notification to the Department of Insurance.

## Covered Person/Patient

first name ______________________ last name ______________________

address ______________________ fax ______________________

city ______________________ state __________ zip __________

daytime phone ______________________ email ______________________

## Person I Authorize to Pursue My Appeal

first name ______________________ last name ______________________

address ______________________ fax ______________________

city ______________________ state __________ zip __________

daytime phone ______________________ email ______________________

## Signature for Authorization

I hereby authorize the above identified person to pursue an appeal on my behalf.

______________________________________________ ____________________

signature of covered person/patient or guardian
if under 18, signature of parent

date

Return this form to:

Illinois Department of Insurance
Office of consumer Health Insurance
External Review Request
320 W. Washington Street
Springfield, IL 62767
877-850-4740 toll free phone
217-557-8495 fax
Insurance.Illinois.gov/ExternalReview