

# Appointment of Authorized Representative for Appeal



This form allows a participant in a health plan administered by Quartz to choose someone to act on their behalf in pursuing an appeal.

Please complete the form and return by mail to Quartz, Attn: Appeals Specialists, 840 Carolina Street, Sauk City, WI 53583, by email to AppealsSpecialists@QuartzASO.com, or by fax to (608) 644-3500.

Name:	ID Number:
Name of Service:	Provider Name:
Date of Service:	Location of Service:

Please complete the information about your authorized representative:

Name of Authorized Representative:		
Address of Authorized Representative:		
City:	State:	ZIP:
Phone:	Email:	

I, \_\_\_\_\_ (participant)  
hereby appoint \_\_\_\_\_ (authorized representative)

to act on my behalf in connection with the appeal of the above noted service. I authorize my representative to receive any and all information that is provided to me and to act for me in providing any information to Quartz and / or my group health plan that relates to the appeal.

**Note: All information and notifications from Quartz and / or your group health plan will be directed to your authorized representative and to you, unless you direct otherwise by checking the applicable box below -**

- Distribute only to me
- Distribute only to my Authorized Representative

This authorization is only valid for the duration of the appeal. If you sign this form, you may revoke the authorization at any time by notifying Quartz in writing at the above address.

Signature of participant or legal representative:	Date:
Printed Name:	