

Appointment of Representative

This form allows a Quartz member to choose someone to act on their behalf in pursuing an appeal.

Please complete the form and return by:

Mail: Quartz, Attn: Appeals Specialists, 840 Carolina Street, Sauk City, WI 53583

Email: AppealsSpecialists@QuartzBenefits.com

Fax: (608) 644-3500

Member Name:		Member ID Number:	
Medicare Number (beneficiary as party) or National Provider Identifier (provider or supplier as party):			
Member Address:			
City:		State:	ZIP Code:
Member Phone Number (with Area Code):		Email:	
Provider Name:		Name of Service:	
Location of Service:			Date of Service:

I, _____ (member) hereby appoint _____ (authorized representative) to act on my behalf in connection with the appeal of the above noted service. I authorize my representative to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance, or request wholly on my behalf. I understand that personal medical information related to my request may be disclosed to the representative indicated below.

Signature of Party Seeking Representation: _____ Date: _____

Please complete the information about your authorized representative:

Name of Authorized Representative:		Professional status or relationship to the party, e.g. attorney, relative, etc.)	
Address of Authorized Representative:			
City:		State:	ZIP Code:
Phone Number (with Area Code):		Email:	

I, _____ hereby accept the above appointment.

Signature of Representative: _____ Date: _____