NorthCare Network

1230 Wilson Street
Marquette, Michigan 49855

Notification of Appeal Request:
If the beneficiary elects to have the provider submit an appeal on their behalf, please ensure that all required information is completed and that the beneficiary's signature is obtained to authorize the provider to act in this capacity. Once all sections of the form have been finalized, please return the completed document by fax to NorthCare Network at 248-406-1287, Attention: Appeals Department.

Date:

Name:

DOB:

Address:

Hospital:

Reason for Appealing:

Type of Appeal: ☐ **standard** ☐ **expedited**

Additional Evidence: ☐ **none** ☐ **enclosed** ☐ **will be provided at peer review**

I hereby designate and authorize this hospital to serve as my Authorized Representative for all activities related to my appeal. This authorization expressly permits the hospital to request, obtain, receive, and review any and all information required for the processing of my appeal; to submit documentation or evidence on my behalf; and to receive all notices, determinations, correspondence, or decisions issued by the agency or its contractors regarding this appeal.

I understand that, by granting this authorization, the hospital may be furnished with protected health information and other confidential records necessary for the purpose of representing me in this appeal, consistent with applicable federal and state regulations, including but not limited to 42 CFR § 431.306, 42 CFR § 438.402–438.406, and relevant MDHHS policy.

_____

Print: Patient Name /Legal Guardian Date

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Sign: Patient Signature/Legal Guardian Signature Date